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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

HEALTHAMERICA and PAMELA MERLE,
Petitioners,
v.
EDWARD MENTON,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

THOMAS H. NOLAN, JR.
(Counsel of Record)
MICHAEL S. MCGLOTHREN
VINCENT A. NOLETTO, JR.
WEYMAN W. MCCRANIE, JR.
BROWN, HUDGENS,
RICHARDSON, P.C.
Post Office Box 16818
Mobile, Alabama 36616
(205) 344-7744

WILLIAM H. GINSBURG
DIANA L. WINFREY
DANIEL J. YAKOUBIAN
WOOD, LUCKSINGER & EPSTEIN
1900 Avenue of the Stars
Suite 1700
Los Angeles, California 90067
(213) 557-2009
Attorneys for Petitioners

Of Counsel:
ALAN BLOOM
JOHN SOUTHWORTH
Maxicare Health Plans, Inc.
5200 West Century Boulevard
Los Angeles, California 90045

December 12, 1989

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

QUESTIONS PRESENTED

(1) Whether the Employee Retirement Income Security Act ("ERISA") preempts state common law fraud claims, including unlimited punitive damages, which arise out of the process of explaining plan options and coverages to participants in an existing welfare benefit plan.

(2) Whether Alabama's "twisting statute" is a law which regulates the business of insurance under Section 514(b) of ERISA and is thus saved from preemption.

(3) Whether a punitive damages award must be proportionate to a Plaintiff's actual damages and to the character of a Defendant's alleged misconduct to avoid violation of a Defendant's rights to substantive due process under the Fourteenth Amendment.

(4) Whether the Alabama standard governing whether punitive damages may be awarded for civil fraud violates the due process clause of the Fourteenth Amendment.

(5) Whether the Alabama trial and appellate procedures allowing the jury ungoverned and unlimited discretion in awarding punitive damages for civil fraud violates the due process clause of the Fourteenth Amendment.

PARTIES TO THE PROCEEDING

Health America * and Pamela Merle
Edward Menton

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* Menton sued "Health America" and Pamela Merle. HealthAmerica and the Mobile Press Register, Inc. entered into a contract (Group Application) whereby HealthAmerica agreed to provide certain health care services and benefits in accordance with the provisions of a Group Subscription Agreement and Schedule of Benefits. According to the Group Subscription Agreement, HealthAmerica Alabama L. P., was the legal entity providing health care services and benefits. HealthAmerica Alabama L. P. was formed in December of 1983 to operate a health maintenance organization in Alabama. Its ultimate general partner is HealthAmerica G. P., Inc., which is a wholly owned subsidiary of HealthAmerica Corporation. Neither HealthAmerica G. P., Inc., nor HealthAmerica Corporation operate health maintenance organizations. In November of 1986, all of the outstanding stock of HealthAmerica Corporation was acquired by Maxicare Health Plans, Inc. In March of 1987, the name of HealthAmerica Alabama L. P., was changed to Maxicare Alabama, L. P. In August of 1987, Maxicare Southeast Health Plans, Inc., acquired the assets and liabilities, but not the partnership interest of Maxicare Alabama L. P., and continued to conduct Alabama operations. The following are companies that may be deemed affiliates or subsidiaries of Maxicare Southeast Health Plans, Inc., or HealthAmerica Corporation: Account Management Services, Inc.; American Medical Plan, Inc.; Bressco, Inc.; Family Health Services, Inc.; Fhills Partnership; General Med Investors, Ltd.; General Medical Centers, Inc.; HCS Computer, Inc.; HealthAmerica Frankford, Inc.; HealthAmerica G.P., Inc.; HealthAmerica Partners, L.P.; HealthAmerica Tennessee, Inc.; Healthcare Alternatives, Inc.; Healthcare Assurance Company, Ltd.; Healthcare Consultants, Inc.; Healthcare USA Inc.; Highland Medical General Partnership; Highland Medical Limited Partnership; Independence Health Plan, Inc.; Independence Health Plan of Southeastern Michigan, Inc.; Lomita-Torrance Building Joint Venture; Mauli-Ola, Inc.; Maxicare; Maxicare Alabama, L.P.; Maxicare Arizona, Inc.; Maxicare Arkansas, Inc.; Maxicare Computing, Inc.; Maxicare/HealthAmerica Florida, Inc.; Maxicare HealthAmerica Health Plan of Arizona, Inc.; Maxicare/HealthAmerica Nebraska, Limited Partnership; Maxicare Health Insurance Company; Maxicare Health Plan of Missouri, Inc.; Maxicare Health Plans, Inc.; Maxicare Health Plans of Kentucky, Inc.; Maxicare Health Plans of the Midwest, Inc.; Maxicare Holdings, Inc.; Maxicare Kentucky, Inc.;

Maxicare Life and Health Insurance Company; Maxicare Louisiana, Inc.; Maxicare Maryland, L.P.; Maxicare Midwest Health Plans, Inc.; Maxicare New Jersey, Inc.; Maxicare New York, Inc.; Maxicare North Carolina, Inc.; Maxicare North Texas, Inc.; Maxicare Pharmacies, Inc.; Maxicare/UHS Nevada, Inc.; Maxicare Utah, Inc.; Maxicare Virginia, L.P.; Maxicare Washington, Inc.; National Pharmaceutical Services, Inc.; Penn Health Corporation; RCP, Inc.; Tucson—Group Health Medical Associates, P.C.

Out of an over-abundance of caution, Petitioners are serving the Attorney General of Alabama with this petition, pursuant to 28 U.S.C. § 2403(b), even though they are not challenging the constitutionality of any statute; rather, they are challenging the award of punitive damages based on a claim of common law fraud.

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IN THE

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OCTOBER TERM, 1989

No.

HEALTHAMERICA and PAMELA MERLE,
Petitioners,

v.

EDWARD MENTON,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

The Petitioners, HealthAmerica and Pamela Merle, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of Alabama entered in this proceeding on July 21, 1989.

OPINIONS BELOW

The opinion of the Supreme Court of Alabama is reported at 23 ABR 3436 (1989) (Ala. Bar Rep.), and appears in App. A, 1a-44a. The Circuit Court of Mobile County, Alabama, issued no opinion.

JURISDICTIONAL STATEMENT

The opinion and judgment of the Supreme Court of Alabama, affirming the $1,800,000.00 judgment against Petitioners, was entered on July 21, 1989. Petitioners filed a timely Application for Rehearing on August 4, 1989, which was denied on September 15, 1989 and no further opinion was issued. App. B, 45a-46a. This petition for

writ of certiorari is being filed within ninety (90) days from the denial of Petitioners' Application for Rehearing in the Supreme Court of Alabama. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

This case involves sections 2, 101, 102, 104, 401, 404, 409, 502, and section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001, 1021(a), 1022, 1024(b), 1101, 1104, 1109, 1132, and 1144(a) & (b); the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1988); the Fourteenth Amendment of the United States Constitution; and *Ala. Code*, § 27-12-6 (1975). The relevant portions of these provisions are reproduced at App. D, 50a-63a.

STATEMENT OF THE CASE

A. Material Facts

Prior to 1985, Respondent's employer, the Mobile Press Register, Inc. ("MPR"), established an employee welfare benefit plan. The MPR solicited proposals from different insurers as a routine matter each year for possible inclusion in its welfare benefit plan, in order to provide "the best benefit package for our employees." In the spring of 1985, the MPR entered into negotiations with two health maintenance organizations (Prime Health and Respondent HealthAmerica) for the purpose of possibly including these HMOs as alternatives to the traditional insurance option within its benefit plan. On May 15, 1985, the MPR entered into a written contract with HealthAmerica whereby HealthAmerica agreed to provide certain health care benefits to eligible members of the MPR group and their dependents.

It is undisputed that Respondent was a participant in the MPR's welfare benefit plan prior to July 1, 1985,

under the traditional health insurance policy, was a participant in the MPR's plan after July 1, 1985, and remains an employee and participant in the MPR's plan. Under the traditional health insurance option in which Respondent was enrolled prior to July 1, 1985, Connecticut General paid 80% of the cost of physical therapy and medical appliances, such as crutches, braces, and walkers.

The Assistant General Manager at the MPR, David Parker, solicited information from insurers and HealthAmerica, negotiated with HealthAmerica, and signed the May 15 agreement between HealthAmerica and the MPR. Parker sent a letter and a packet of information from his office to MPR employees, including Respondent. Parker's May 23, 1985 letter to MPR employees states, "Management will soon offer employees, as an alternative medical benefit selection, the two health maintenance organizations (HMOs) in our area. . . ." Parker also prepared and distributed a two page "summary of benefits."

Although Respondent received this literature from the MPR, he could not determine whether physical therapy, crutches, and braces would be covered under the new HMO options. Respondent was concerned about these benefits because his son suffered certain medical problems which would require surgery followed by physical therapy. Respondent was interested in a program that would pay more than the 80% paid under the traditional insurance option. Respondent went to see Parker with his question, and Parker suggested that Respondent should go to one of the scheduled informational meetings and ask the representatives of the two new plan options. Parker testified that he avoided answering questions about coverage: "I try and avoid putting myself in the position of answering specific questions about coverage just to avoid any liability on the company's part as to making a representation of coverage."

Respondent attended a June 17, 1985 meeting at the MPR during which Petitioner Pamela Merle (a Health-

America employee) explained the HealthAmerica option, a representative from Prime Health explained its option, and Parker explained the traditional Connecticut General insurance. At the end of the meeting, Respondent approached the HMO representatives and informed them of his son's need of surgery and subsequent rehabilitation. He said, "and I asked how they covered or would it be covered or something like that." Respondent testified, "I was told it would be covered a hundred percent by HealthAmerica."

The HealthAmerica schedule of benefits does cover physical therapy or rehabilitation at one hundred percent, but only for the first two months of treatment. There is no evidence that Ms. Merle was aware of the limitation on physical therapy or rehabilitation benefits when she answered Respondent's question at the meeting.

Immediately after the meeting, Parker, who was present when Respondent asked his question, told Respondent, "You're not going to lose anything if you go that way," meaning HealthAmerica.

On June 24, 1985, Respondent enrolled himself and his family under the HealthAmerica option, with an effective date of July 1, 1985. He testified that he did not receive a copy of the actual Schedule of Benefits under the HealthAmerica program until *after* he had enrolled. Although he received the Schedule before his son commenced therapy on July 30, 1985, he was concerned because the Schedule clearly indicated that physical therapy or rehabilitation services were covered for only two months from the beginning of such treatment. Respondent again consulted Parker and told him, "It looks like this particular coverage on rehabilitation is limited or excluded." Parker suggested Respondent call Ms. Merle at HealthAmerica.

Respondent called Ms. Merle. He told Merle he had received the Schedule of Benefits and it indicated that

coverage was limited, and, "She said she wasn't sure about that, she would check on it and call me back." Merle called him back and confirmed that he was reading the schedule correctly. Respondent then went to Parker and got him involved with handling the problem. There were several telephone communications between Respondent, Parker, and HealthAmerica, attempting to resolve the situation, and Parker wrote a letter to HealthAmerica. By letter of November 11, 1985, HealthAmerica said it would extend rehabilitation benefits for an additional sixty days. Ultimately, HealthAmerica paid for Respondent's son's physical therapy for only the first sixty days, through September 30, 1985, and did not extend benefits for the additional sixty days. Respondent's actual or out-of-pocket damages equal $2,412.00. App. at 24a.

The Group Subscription Agreement provides for the filing of written proof of a claim for benefits and, if such a claim is denied by HealthAmerica, the Agreement also provides for a formal grievance procedure, which includes an appeal to HealthAmerica's Board of Governors. While Respondent did attempt an informal resolution of his problem, it does not appear from the record that he exhausted these administrative procedures. Instead, Respondent filed a one count claim for common law fraud. The complaint was not predicated on *any* Alabama statutory provision.

B. Presentation of Federal Issues

Over a month before trial, Petitioners filed a motion for summary judgment and motion to strike Respondent's jury demand, supported by a brief, pursuant to the Employee Retirement Income Security Act of 1974 (ERISA). Petitioners' motions were denied on January 8 and 11, 1988, respectively. The day before trial, Petitioners filed a supplemental memorandum of law in support of their ERISA motions.

At the close of the Plaintiff's case, Petitioners moved for a directed verdict based upon ERISA preemption, *inter alia*. When the motion was argued, the trial court, *ex mero motu*, asserted that Alabama's "twisting" statute, *Ala. Code* § 27-12-6 (1975), and HMO statute, *Ala. Code* § 27-21a-1 (1975), might "save" Respondent's fraud claim from ERISA preemption. Despite Petitioners' objections that they were not sued for violation of those statutes and that neither statute provides a private cause of action, the trial court denied the Petitioners' motion and submitted the case to the jury on Respondent's common law fraud claim.

The jury returned a verdict for Respondent in the amount of $1,800,000.00. Final judgment was entered on January 14, 1988. Respondent subsequently filed an Amended Complaint alleging a violation of Alabama's twisting statute.

Petitioners filed a timely motion for JNOV or, in the alternative, for new trial or remittitur, which included challenges to the constitutionality of the punitive damages award. The trial court entered a written order denying Petitioners' motions and holding that Petitioners' federal constitutional issues were timely raised:

> [T]he Court has considered Defendants' claims that the imposition of punitive damages, both generally under Alabama law and specifically in the amount and as returned by the jury under the facts of this case, is unconstitutional under the Alabama as well as the United States Constitutions (particularly, the Due Process Clause of the 5th Amendment; the Due Process, Equal Protection, and Privileges and Immunities Clauses of the 14th Amendment; the Excessive Fines Clause of the 8th Amendment; the Contracts Clause and prohibition of Ex Post Facto laws of Article I, Section 10, Clause 1). Although these arguments were timely raised and effectively presented, the Court is unpersuaded by such arguments and therefore holds that the imposition of punitive

> damages, both generally under Alabama law and specifically in the amount as returned by the jury under the facts of this case, is constitutional under both the state and federal constitutions.

App. at 48a.

On appeal, a majority of the Alabama Supreme Court affirmed the judgment of the trial court, including the damages award. The majority adopted an alternative standard on the issue of ERISA preemption which finds no support in the decisions of this Court: A state law is not preempted unless it "purports" to regulate, directly or indirectly, "the terms and conditions of a plan." This alternative approach to ERISA preemption directly contravenes the intent of Congress in enacting the broadest express preemption clause in federal law. The Alabama court reached its opinion notwithstanding that: (a) ERISA and its legislative history demonstrates that Congress intended federal standards to be the exclusive source of law governing ERISA plans; (b) the imposition of inconsistent state law remedies in the administration of ERISA plans impedes interstate commerce and deters employers, insurers, and health care providers, from offering new benefits and options to participants; (c) Congress has specifically mandated the disclosure of information regarding plan benefits and coverages to participants and provided remedies for violation of said provisions and the allowance of state common law fraud actions interferes with this congressional plan and civil enforcement scheme; (d) the award of punitive damages under state fraud actions directly supplants the exclusive ERISA enforcement scheme and subject plans to ungovernable and inconsistent state standards.

REASONS FOR GRANTING THE WRIT

I. The Preemption Standard Adopted By The Alabama Court Was Rejected By Congress

Prior to the enactment of ERISA, Congress was dissatisfied with attempts at pension plan regulation which left many aspects subject to a conflicting system of state and federal regulation. H. R. Rep. No. 533, 93d Cong., 1st Session 2-5 (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639, 4640-43 [hereinafter *Report* 533].[1] In enacting ERISA, Congress sought to protect interstate commerce and the interests of participants in employee benefit plans by creating a comprehensive federal regulatory scheme which would require the disclosure and reporting of information to participants, establish uniform standards of conduct and fiduciary obligations, and would provide certain specified remedies. ERISA Section 2, 29 U.S.C. § 1001 (1982). To insure that this framework would be preeminent, eliminating the threat of conflicting and inconsistent state regulation, Congress expressly preempted, with narrow exceptions, all state laws which "relate to any employee benefit plan." ERISA Section 514 (a), 29 U.S.C. § 1144(a) (1982).

ERISA's sponsors emphasized that the bill was intended to foreclose non-federal regulation of employee benefit plans and to eliminate the threat of conflicting and inconsistent state laws. 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams); 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits). As the Court recognized in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983), the original House and Senate versions would have limited

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[1] For a general discussion of plan regulation prior to ERISA, see, Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. Pitt. L. Rev. 427 (1987); and Note, *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 Vand. L. Rev. 607 (1989).

ERISA preemption to state laws dealing with matters expressly covered by ERISA's provisions—reporting, fiduciary responsibility, etc.—but the Joint Conference committee rejected these narrow provisions "in favor of the present language, and indicated that the Section's preemptive scope was as broad as its language." The preemption standard adopted by the majority of the Alabama court narrows the scope of preemption to only state law which "purports to regulate, directly or indirectly, the terms and conditions of a plan." This narrow standard is entirely inconsistent with the extremely broad express preemption provision enacted by Congress after considering and rejecting narrower versions.

Of course, if Congress determines that a particular species of state law should be excluded from the broad sweep of Section 514(a), it can easily do so by enacting additional narrow exceptions to preemption.[2] Additionally, Congress intended that the federal courts would develop a body of federal common law of ERISA to deal with issues involving rights and obligations under ERISA regulated welfare and pension plans. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. ——, 103 L.Ed. 2d 80, 92 (1989); *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n. 26 (1983).

The preemption standard advanced by the Alabama court ignores the legislative history of § 514(a) and the intent of Congress that the administration of benefit plans would be governed by uniform federal standards.

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[2] *See, e.g.*, Pub. L. No. 97-473, § 301(a), 96 Stat. 2611, 2613 (1983) (codified at 29 U.S.C. § 1144(b)(5)(A) (1982) (Hawaii Prepaid Health Care Act); Pub. L. No. 98-397, 98 Stat. 1436 (1984) (codified at 29 U.S.C. § 1144(b)(7) (Supp. V 1988) (qualif. domestic relations orders).

II. The Decision Of The Alabama Court Is In Direct Conflict With The Decisions Of This Court And Other Federal Appellate Courts On The Scope Of Federal Preemption Under Section 514(a)

The decision of the Alabama court has resulted in the anomalous situation that a state law fraud claim in an Alabama court is not preempted while the identical claim in a federal district court in Alabama is preempted. This intolerable violation of the supremacy clause, U.S. Const. Article VI, must be resolved. The decisions of this Court, the Fifth, Ninth, and Eleventh Circuits all hold that a claim such as Respondent's is within the scope of Section 514(a) because it is concerned with and arises out of the administration of an ongoing ERISA benefit plan. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989); *Davidian v. Southern California Meat Cutters Union & Food Employees Benefit Fund*, 859 F.2d 134 (9th Cir. 1988); *Herman Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464 (11th Cir.), *cert. denied*, 481 U.S. 1016 (1987).

In *Shaw v. Delta Air Lines, Inc.*, the Court recognized that Congress used the words "relate to" in Section 514(a) in their broad sense and that the Courts must give effect to the intent of Congress and the plain language of the preemption clause. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43 (1987), the Plaintiff brought state law claims for "Tortious Breach of Contract," "Breach of Fiduciary Duties," and "*Fraud in the Inducement*" against the insurer providing benefits under the plan. After reviewing the legislative history of Section 514(a) and reaffirming that, "the express preemption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern,'" *id.* at 46, the Court stated that all three of the Plaintiff's common law claims related to the benefit

plan: "There is no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan and therefore fall under ERISA's express pre-emption clause, § 514(a)." *Id.* at 47.

In *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989), the Eleventh Circuit held that Alabama state law claims of fraudulent misrepresentation and negligence arising out of representations made to induce the Plaintiffs to purchase a new or different health plan related to the ERISA plan and were preempted. In determining whether a cause of action "relates to" an employee benefit plan, the Eleventh Circuit looked to whether the conduct giving rise to such claim was not "wholly remote in content" from the benefit plan. *Id.* at 794. In the present case, Respondent brought his fraud action when he failed to receive physical therapy and rehabilitation benefits beyond the sixty days specified in the Health-America schedule of benefits. Respondent's claims are based on certain representations which were made to him during the process, established by his employer, of explaining the coverages and benefits available under the three options within his employer's welfare benefit plan. Clearly, Respondent's claim would be preempted under the *Farlow* standard.

Similarly, in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), the Plaintiffs claimed in their Amended Complaint that they were induced into purchasing certain coverage under an ERISA plan and, in reliance upon representations regarding coverage under that plan, into discontinuing their coverage under another existing policy of insurance. The Eleventh Circuit held that such Alabama fraud claims "relate to" the plan and are preempted. A certified copy of the Amended Complaint in *Belasco* was submitted to the Alabama Supreme Court following oral argument in this case.

The decision of the Alabama court is also in direct conflict with *Davidian v. Southern California Meat Cutters*

Union & Employees Benefit Fund, 859 F.2d 134 (9th Cir. 1988). In *Davidian*, the Plaintiff elected to switch or change options within his employer's welfare benefit plan as a result of certain representations made to him concerning the merits of the various available options. The Ninth Circuit held that the Plaintiff's fraud and deceit claims "related to" the plan and were preempted.[3]

In reaching its decision, the majority of the Alabama court relied on several inapplicable federal district court decisions which involved suits against employers for wrongful breach of the employment contract, for representations which induced the Plaintiff to accept employment, and for representations made by the employer during the ordinary course of business and not as part of the administration of a benefit plan. None of these cases can be properly applied to the facts of this case where the representation providing the basis for Respondent's suit occurred during the process of explaining coverages and options under an existing welfare benefit plan.

The majority opinion also relied on *Perry v. P*I*E* Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989). *Perry* is factually distinguishable from the present case as the misrepresentation in *Perry* arose out of the sale of the corporation which employed the Plaintiffs and concerned the continuation or termination of employment if the Plaintiffs did not take certain action concerning a stock investment plan. The representations of the employer

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[3] Numerous other decisions recognize that a fraud or fraud in the inducement claim "relates to" the administration of the benefit plan and is preempted: *Herman Hospital v. MEBA Medical & Benefits Plan*; *Johnson v. District Two Marine Engineering Beneficial Association*, 857 F.2d 514 (9th Cir. 1988); *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988); *Reilly v. Blue Cross & Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir. 1988); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464 (11th Cir. 1986); *Tucker v. Employers Life Ins. Co.*, 689 F. Supp. 1073 (N.D. Ala. 1988); *Comprehensive Care Corp. v. Doughtry*, 682 F. Supp. 516 (S.D. Fla. 1988).

were made by the employer in its capacity as employer rather than by any entity providing benefits as part of an employee welfare benefit plan, and the misrepresentation did not occur during either the employer's or provider's conduct in administering a benefit plan. In the instant matter the representation occurred during the administration of an existing welfare benefit plan and the explanation of options available under that plan. This Court should accept this petition and take this opportunity to insure that factually distinguishable cases are not used to narrow improperly the scope of ERISA preemption.

To the extent that *Perry* could be applied to the facts of this case, it is in conflict with the weight of federal authority. It is abundantly clear from *Pilot Life*, *Farlow*, *Belasco*, and *Davidian* that Congress did intend to preempt state laws regulating fraud or representations which occur during or arise out of the administration of an ERISA governed welfare benefit plan. The explanation of plan benefits and options within a plan is obviously part of the administration of the plan and, in fact, the disclosure of information to participants is specifically regulated by Congress. Thus, Respondent's claims "relate to" the benefit plan and are preempted because they arise out of the administration of the plan and the conduct giving rise to his claims is not "wholly remote in content" from the benefit plan.

III. Congress Specifically Regulated Information Disclosure And Fiduciary Standards Applicable To The Administration Of Welfare Plans, And The Application Of State Remedies In This Area Would Interfere With ERISA's Exclusive Enforcement Scheme

A. *Congress Specifically Regulated The Disclosure Of Information About Plan Benefits*

In the Court below, Respondent insinuated that he is left without a remedy if his state claim is preempted. However, Congress provided for the disclosure of benefit

information to plan participants and provided remedies if these disclosure requirements are not met.

One of the primary purposes of Congress in enacting ERISA was to insure that plan participants would receive accurate and full information about the benefits available under a plan. *Rodriguez v. Meba Pension Trust*, 872 F.2d 69, 74 (4th Cir.) *cert. denied*, 110 S.Ct. 202 (1989); *Edwards v. State Farm Mutual Auto Ins. Co.*, 851 F.2d 134 (6th Cir. 1988); ERISA Section 2, 29 U.S.C. § 1001 (a) and (b); *Report* 533, at 7-11, 18-20, *reprinted in* 1974 U.S. Cong. & Adm. News 4645-50, 4656-58; 120 Cong. Rec. 29928, 29931-32 (1974) (remarks of Sen. Williams). Specifically, Congress provided that a sufficiently accurate and comprehensive summary plan description should be furnished to all participants. ERISA Section 101, 29 U.S.C. § 1021(a) (1982); ERISA Section 102, 29 U.S.C. § 1022(a)(1) (1982); ERISA Section 104, 29 U.S.C. § 1024(b) (1982). Plan administrators are also required to make copies of the plan description available for examination by any plan participant in the principal office of the administrator and, upon written request of a participant, to furnish a copy of the latest updated summary plan description. ERISA Section 104, 29 U.S.C. § 1024(b)(2) & (4). Congress even provided criminal penalties for willful violation of the disclosure and reporting requirements of the act. ERISA Section 501, 29 U.S.C. § 1131 (1982).

An ERISA plan "administrator" has a statutory duty of disclosure and reporting. *Moran v. Aetna Life Ins. Co.*, 872 F.2d 296 (9th Cir. 1989); 29 U.S.C. § 1021(a) (1982). Because neither the Group Subscription Agreement nor Schedule of Benefits designates HealthAmerica as the administrator, the MPR as the "plan sponsor" is the administrator. *Moran v. Aetna*; *Davis v. Liberty Mutual Ins. Co.*, 871 F.2d 1134 (D.C. Cir. 1989).

Mr. Parker, acting on behalf of the MPR, solicited and received information from the two new HMO op-

tions. Parker prepared a two page comparative summary of benefits available under the three options which he sent to MPR employees before the June 17, 1985 meeting and before the June 30, 1985 option election date. After receiving information from Parker, including the summary, Respondent went to Parker with his question about coverage under the HealthAmerica option and, instead of either making a copy of the complete schedule of benefits available for Respondent to review in his office or obtaining a schedule for Respondent to review, Parker merely instructed him to attend the informational meetings being held at the MPR.

The MPR may have failed to provide Respondent with a "sufficiently accurate and comprehensive" description of the HealthAmerica option within its welfare benefit plan as required under 29 U.S.C. §§ 1021(a), 1024(b)(1) (1982). The MPR may have failed to make a copy of the HealthAmerica option available for examination by plan participants prior to the option election date, which may be a violation of 29 U.S.C. § 1024(b)(2) (1982). Section 1024(b)(1) imposes a duty on the administrator to furnish a plan description, without requiring a written request, and the failure to supply such information or the distribution of inaccurate or incomplete summary plan description provides the basis for an action under ERISA's civil enforcement scheme. *Davis v. Liberty Mutual*; *Rodriguez v. Meba Pension Trust*. An inaccurate or incomplete summary plan description provided by the administrator, upon which the participant relies, provides the basis for an action for benefits under ERISA. *Edwards v. State Farm*; *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566 (11th Cir. 1985); *Genter v. ACME Scale & Supply Co.*, 776 F.2d 1180 (3rd Cir. 1985); *Kochendorfer v. Rockdale Sash & Trim Co., Inc.*, 653 F. Supp. 612 (E.D. Ill. 1987). Also, if Respondent made a written request to Parker for a complete schedule of benefits and Parker failed to comply before the option election date, July 1, 1985, the MPR would have violated

29 U.S.C. § 1024(b)(4) (1982) for which there would be an additional action under ERISA's enforcement scheme.

In conclusion, Congress specifically regulated the disclosure of information to plan participants so as to enable them to make informed choices regarding plans and options therein, and Respondent may have an action under ERISA's civil enforcement scheme for violation of these provisions. Since Congress has specifically regulated this aspect of the administration of welfare benefit plans and provided remedies for enforcement, the intrusion of state law and remedies into this area is beyond question preempted by Section 514(a). This case should have been remanded to the trial court for a determination of Respondent's rights under 29 U.S.C. § 1132(a) (1982).

B. *Congress Specifically Imposed Fiduciary Standards And Remedies Governing The Conduct Of Health-America As A Plan Fiduciary*

According to the documents governing the Health-America option within the MPR's benefit plan, the Schedule of Benefits and Group Subscription Agreement, HealthAmerica had the responsibility for determining claims for benefits and coverage under the HealthAmerica option. Accordingly, HealthAmerica is an ERISA fiduciary. *Pierre v. Connecticut General Life Ins. Co.*, 866 F.2d 141 (5th Cir. 1989); *Smart v. State Farm Ins. Co.*, 868 F.2d 929 (7th Cir. 1989); *America Federation of Unions Local 102 v. Equitable Life Assurance Society*, 841 F.2d 658 (5th Cir. 1988); ERISA Section 3(21), 29 U.S.C. § 1002(21)(A). "ERISA imposes a prudent man's standard of care upon anyone acting as a fiduciary with respect to an employee benefit plan as defined in the Act." *American Federation of Unions Local 102*, 841 F.2d at 662. Any fiduciary who violates 29 U.S.C. § 1104(a)'s duty to act in the best interest of participants is subject to liability under 29 U.S.C. § 1109(a). *Id.* Pamela Merle

was still in the process of being trained as a representative for HealthAmerica and her answer of Respondent's specific coverage question, obviously given without knowledge of the sixty day limit on rehabilitation benefits, may have constituted a breach of fiduciary duty under ERISA. *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154, 1163 (6th Cir. 1988); *Local Union 2134, UMW v. Powhatan Fuel*, 828 F.2d 710 (11th Cir. 1987).

Additionally, Respondent testified that Ron Scott, a manager at HealthAmerica, called Mr. Parker and told him to tell Respondent not to fill out the formal "grievance forms" sent to him by HealthAmerica because "we're going to take care of this." If this conversation actually occurred and if Respondent failed to pursue his formal grievance or appeal procedures because of this, HealthAmerica could be liable for additional breach of fiduciary duties under ERISA's enforcement scheme. Congress intended that the internal dispute resolution procedures required by the act should be followed, in part, because the exhaustion of such formal procedures creates a fully developed factual record which assists courts in reviewing the actions of fiduciaries. *Makar v. Health Care Corp. of the Mid-Atlantic*, 872 F.2d 80 (4th Cir. 1989) (Plaintiff failed to exhaust the grievance and appeal procedures established by the health maintenance organization).

C. *The Award Of Punitive Damages Under Conflicting And Inconsistent State Law Standards Would Interfere With ERISA's Civil Enforcement Scheme*

Congress provided uniform nationwide standards governing the duties and liabilities of plan sponsors, administrators, and fiduciaries; and Congress enacted a carefully crafted civil enforcement scheme which was intended to be exclusive so as to insure a uniform nationwide source of law. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 54-56. *See also Report* 533, *supra* at 12, 17, *reprinted*

in 1973 U.S. Code Cong. & Admin. News 4649, 4655. Congress recognized that benefit plans were increasingly interstate in nature and intended to promote the growth of benefit plans by providing a uniform set of standards and remedies. *Id.* The Alabama court's imposition of conflicting and inconsistent state law remedies arising out of the process of explaining plan coverages, benefits, and options would discourage the growth and development of benefit plans contrary to the express intent of Congress.

In *Massachusettes Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), the Court held that ERISA Section 409, 29 U.S.C. § 1109(a), providing an action for breach of fiduciary duty, does not allow the recovery of extra contractual or punitive damages by a participant or beneficiary. The Court stated that, "The six carefully integrated civil enforcement provisions . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." 473 U.S. at 146. The majority of the circuits have held that plan participants cannot recover extracontractual or punitive damages for claims, whether designated as state law claims or ERISA claims, that "relate to" the benefit plan. *Amos v. Blue Cross-Blue Shield of Alabama*, 868 F.2d 430, 431 n.2 (11th Cir.), *cert. denied*, 110 S.Ct. 158 (1989). The imposition of state law remedies allowing the award of ungoverned and unlimited punitive damages, such as Respondent's Alabama claims, for conduct occurring during the administration of a benefit plan and the explanation of options and coverages within that plan would emasculate Congress' carefully enacted enforcement mechanism and would discourage plans from offering new options or benefits which might subject them to devastating punitive awards. Whether or not Respondent would prevail on his potential claims for breach of ERISA's information disclosure and fiduciary responsibilities in this case, Congress intended that state law claims such as Respondent's would be preempted.

IV. The Alabama Court Plainly Misconstrued and Misapplied The ERISA Insurance Savings Clause In Direct Conflict With The Decisions Of This Court And Other Federal Appellate Courts

The Alabama court failed to address the question of whether Alabama's "twisting" statute, *Ala. Code* § 27-12-6 (1975), provides for a private cause of action.[4] Instead, having held that Respondent's common law fraud claim is not preempted, the Court opined that "if some other court" decides that such a fraud claim is preempted, "then we would hold that a claim under § 27-16-6 [sic] could still be maintained under the savings clause of ERISA as a state law regulating the business of insurance." App. at 16a. The Court so held even though HealthAmerica, a health maintenance organization, was not engaged in the business of insurance and did not issue policies of insurance. Second, the twisting statute does not meet *any* of the three McCarran-Ferguson Act factors applied by this Court to determine whether a state law regulates the "business of insurance." Third, the judicial creation of private remedies under trade practices acts would allow the different states to regulate the information disclosure and fiduciary standards specifically regulated by Congress and reserved to the federal government under ERISA. Simply put, to allow such remedies would devastate ERISA's exclusive enforcement scheme and the "savings clause" would consume the preemption clause.

In *Pilot Life*, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court established a three tiered test to determine whether a state law is

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[4] This issue was extensively briefed and the Alabama court was well aware that the majority of courts nationwide recognize that a trade practices act does not support a private action unless expressly provided therein. *See Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989).

"saved" from ERISA preemption under Section 514(b)(2): First, a Court must take whatever guidance is available from a "common sense view" of the language of the savings clause itself; second, a Court must consider the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1012; third, and most significant, the Court must consider the relationship between the application of the specific state law and the role of the savings clause in ERISA as a whole.

"A common-sense view of the word 'regulate' would lead to the conclusion that, in order to regulate insurance, a law must not just have an impact on the business of insurance, but be specifically directed toward that industry." *Pilot Life*, 41 U.S. at 50. As the Court noted in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 230, n. 38, "[m]any aspects of insurance companies are regulated by state law, but are not the 'business of insurance.'" Alabama's twisting provision, whether applied to an insurance company or, as in the instant case, an entity not engaged in the business of insurance, does not "regulate" the "business of insurance" as that phrase is used in the narrowing context of McCarran-Ferguson or ERISA.

The first McCarran-Ferguson factor, "the spreading and underwriting of a policyholder's risk," in the one indispensable characteristic of insurance. *Royal Drug Co.*, 440 U.S. at 211-12. *See also Anschulz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988); *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Even District Judge Acker in *Butler v. Fringe Benefits Plan, Inc.*, 701 F. Supp. 804 (N.D. Ala. 1988), a case relied on by the majority of the Alabama court, recognized that Alabama's twisting statute does *not*

spread or transfer policyholder risks.[5] Alabama's twisting statute does not regulate how insurers assign or transfer risks, establish reserves, or otherwise underwrite risks. To the contrary, the twisting provision is simply concerned with prohibiting certain practices in the solicitation of insurance policies and nothing more.

With regard to the second McCarran-Ferguson factor, this Court has observed that the core of the business of insurance is the "relationship between the insurer and the insured, the type of policy which could be issued, its reliability, interpretation, and enforcement." *Royal Drug Co.*, 440 U.S. at 215-16. *See also Pilot Life*, 481 U.S. at 51. Unlike the mandated benefits law "saved" in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the twisting statute does not regulate the terms, provisions, or benefits available under a policy of insurance—those things integral to the insurer-insured relationship. Rather, according to the opinion of the Alabama court, the twisting statute somehow allows the imposition of a private remedy for certain prohibited practices.

In *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, the Fourth Circuit found that the Plaintiff's state law claims, including a claim under Virginia's Unfair Trade Practices Act, were not saved from preemption as they did not bear upon the "busines of insurance."[6]

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[5] The Alabama court chose to rely on Judge Acker's opinion in the *Butler* case even though the Court was aware that Judge Acker has a record of being reversed on ERISA matters: *Amos v. Blue Cross-Blue Shield of Ala.*, 681 F. Supp. 1515, *reversed*, 868 F.2d 430 (11th Cir. 1989); *Whett v. Goodyear Tire & Rubber Co.*, 676 F. Supp. 1119, 1132 (N.D. Ala. 1987) (Judge Acker was forced to reverse himself in face of overwhelming precedent).

[6] Plaintiff's claims included an alleged violation of Section 38.1-52.1 of the Virginia Unfair Trade Practices Act, which provides as follows: "No person shall make, issue, circulate . . . any estimate, illustration, circular, statement, sales presentation, omission, or comparison which (1) Misrepresent the benefits, advantages, conditions, or terms of any insurance policy." 780 F.2d at 422 n.4.

Similarly, in *Dennette v. Life of Indiana Ins. Co.*, 693 F. Supp. 959 (D. Colo. 1988), the Court held that claims under Colorado's code, including a claim under a statute which prohibited "[m]isrepresenting pertinent facts or insurance policy provisions relating to coverages at issue" were not saved from ERISA preemption because such state laws did not effect the transferring or spreading of policyholder risk and were not integral to the insurer-insured relationship because they did not seek to regulate the substantive terms of the insurance contract itself. *See also Keel v. Group Hospitalization Medical Services, Inc.*, 695 F. Supp. 223 (E.D. Va. 1988); *Rollo v. Maxicare of Louisiana, Inc.*, 695 F. Supp. 245 (E.D. La. 1988).

The twisting statute, as applied in this case, also fails to meet the third McCarran-Ferguson criteria. Although the Alabama Trade Practices Law is generally directed to the insurance industry, the twisting provision is not so restricted as it applies to any "person." The evidence was undisputed that HealthAmerica is a health maintenance organization and not an insurance company and did not issue any policy of insurance to Respondent or to the welfare benefit plan. There is authority that health maintenance organizations and other alternative health care providing arrangements are not generally considered engaged in the business of insurance for purposes of the McCarran-Ferguson Act. *Royal Drug Co.*, 440 U.S. at 225-26. The Alabama court impliedly held that HealthAmerica was engaged in the busines of insurance and subject to state insurance regulations even though it did not discuss this question or cite any authority for the proposition that HMOs are subject to such regulation. Further, Alabama's twisting statute would not be saved *even if* HealthAmerica was an insurance company engaged in the busines of insurance because the statute fails to satisfy the other two McCarran-Ferguson factors.

Additionally, a claim for punitive damages against an ERISA administrator or fiduciary based upon violation of

a state insurance trade practices act provision, even *if* the state law otherwise satisfied the above criteria, would be preempted because of its disruption of ERISA's exclusive civil enforcement scheme. *Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *cert. denied*, 109 S.Ct. 3216 (1989); *Commercial Life Ins. Co. v. Juliano*, 764 P.2d 1059 (Cal. 1988), *cert. denied*, 109 S.Ct. 2087 (1989).

As shown above, the disclosure of information to plan participants concerning plan coverages and options is specifically governed under ERISA, as is the standard of conduct which governs ERISA fiduciaries in their dealings with plan participants, and Respondent may have a claim under ERISA's enforcement scheme for violation of these areas specifically regulated by Congress. Accordingly, it appears that the ERISA "deemer clause," 29 U.S.C. § 1144(b)(2)(B), may also be implicated as "the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure, and non-forfeitability." *FMC Corp. v. Holliday*, 885 F.2d 79, 88 (3rd Cir. 1989). To the extent that Alabama's twisting statute purports to treat HealthAmerica as an insurance company and purports to regulate HealthAmerica's conduct in the explanation of coverages and administration of benefits under the MPR welfare benefit plan, the deemer clause may require the preemption of Alabama's twisting provision even *if* said provision was otherwise saved from ERISA preemption as a law regulating the business of insurance.

As the dissent in this case indicated, Respondents' claim should be remanded to the trial court for determination of his remedies under ERISA's civil enforcement scheme. In the unlikely event that Respondent's situation is not governed by ERISA's information and fiduciary standards or enforcement scheme, it is within the power of Congress to broaden the information requirements or expand the enforcement scheme. Additionally, the federal courts have

a duty to develop the federal common law of ERISA to fulfill the purposes of the Act. However, regardless of whether Respondent will prevail in an ERISA action against Petitioners, Congress has expressly preempted his state law claims; and the conflict in the application of federal law, created by the Alabama court, must be resolved.

V. The Disproportionate Punitive Damages Award And The Alabama Standard Governing Punitive Damages Awards For Civil Fraud Violate The Due Process Clause Of The Fourteenth Amendment

The punitive damages award represents 745 times the amount of Plaintiff's actual damages and was made based upon a punitive damages standard which is incomprehensibly vague and unintelligible.[7] The verdict is so grossly disproportionate to the character of Petitioners' alleged misconduct as to be constitutionally excessive and to violate Petitioners' rights to substantive due process. *See Browning-Ferris Industries v. Kelco, Inc.*, 109 S.Ct. 2909 (1989). Further, Petitioners were given no warning that their conduct would be subject to such penalties, and the absence of a meaningful standard resulted in the deprivation of Petitioners' "property" rights without due process of law.

Fundamental to the concept of due process is an element of fair warning and notice of what conduct will give rise to punishment so that a person of ordinary intelligence would have a reasonable opportunity to understand what conduct is prohibited. *See Grayned v. City of Rockford*, 408 U.S. 104, 108-109 (1972); *Giacco v. Pennsylvania*, 382 U.S. 399, 402-403 (1977).[8] The Ala-

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[7] The meaningless standard customarily applied in Alabama is stated in the opinion, App. A, 22a-24a: "so recklessly done as to amount to the same thing" as intentional fraud.

[8] Although Defendants' constitutional issues were first raised post-trial, the trial judge carefully considered them and specifically

bama standard allowing the imposition of punitive damages for fraud does not provide a rational or intelligible standard for the jury to use in determining whether to award punitive damages and fails to provide potential Defendants with an adequate notice of what conduct will subject them to punitive sanctions.

A law is unconstitutionally vague "when men of common intelligence must necessarily guess as to its meaning and differ as to its application." *Connally v. General Construction Co.*, 269 U.S. 385, 391 (1926); *Coates v. City of Cincinnati*, 402 U.S. 611 (1971); *Davis v. Schnell*, 81 F. Supp. 872 (S.D. Ala.), *aff'd per curiam*, 336 U.S. 933 (1949). Anyone of "common intelligence" would have to "guess" as to the meaning of the standard used in Alabama, as the jury did in this case. As a result of such a "standard," juries are given an unrestrained license to impose their own personal biases and prejudices against unpopular Defendants.[9]

VI. The Alabama Procedure Allowing The Jury Ungoverned And Unlimited Discretion In Awarding Punitive Damages For Civil Fraud Violates The Due Process Clause Of The Fourteenth Amendment

The jury had unlimited discretion in determining the amount of punitive damages awarded to Menton.[10] One

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held that they were "timely" raised. App., at 48a. Further, there is ample precedent to support the power of this Court to consider these issues. *Hathorn v. Lovorn*, 457 U.S. 255, 262-65 (1982).

[9] Plaintiff's counsel repeatedly referred to Defendant Health-America as an "insurance company" at trial even though Health-America is a health maintenance organization.

[10] In 1987, the Alabama legislature enacted "tort reform" statutes which capped punitive damage awards at $250,000.00, with exceptions, and imposed a "clear and convincing evidence" standard for the award of punitive damages. Ala. Code Ann. §§ 6-11-20; 6-11-21 (Supp. 1989). However, these statutes do not apply to the case at bar. Ala. Code Ann. § 6-11-30 (Supp. 1989). Further, the statute capping punitive damage awards is currently under attack in at

court has held that due process places a limit on punitive damage awards in some contexts. *See Juzwin v. Amtorg Trading Corp.*, 705 F. Supp. 1054, 1064, *reh'g granted*, 718 F. Supp. 1233 (D.N.J. 1989). Further, Petitioners submit that the Alabama punitive damages scheme chills their "fundamental right of access to the courts by authorizing unlimited punitive damages," and members of this Court have noted the amount of jury discretion in awarding punitive damages "may violate the Due Process Clause." *See Bankers Life & Casualty v. Crenshaw*, 486 U.S. 71, 108 S.Ct. 1645, 1655 (1988) (O'Connor, J., dissenting); *see also Browning-Ferris Industries v. Kelco, Inc.*, 109 S.Ct. 2909 (1989).

As a matter of common law in Alabama, punitive damages are intended to punish a civil defendant and deter future similar conduct. *See Aetna Life Ins. Co. v. Lavoie*, 470 So.2d 1060 (Ala. 1984), *rev'd.*, 475 U.S. 813 (1986); *Badgett v. McDonald*, 304 So.2d 228 (Ala. Civ. App. 1974). However, under Alabama's scheme Petitioners were not provided any semblance of the procedural and substantive safeguards afforded criminal defendants before they can be punished: The jury was not given meaningful guidelines to apply in determining the award of punitive damages; there was no limit on the amount which could be awarded; there was no requirement that the punitive award bear any particular relationship to the amount of actual damages; there was no increased burden of proof required for the imposition of such punishment; and there was no meaningful appellate review of the jury's excessive award. Such a scheme violates the Due Process Clause of the Fourteenth Amendment.

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least one court in Alabama. *Trawick v. Michaels of Oregon Co.*, No. 88-C-413-N (N.D. Ala. 1989). If that statute is struck down, then the unbridled and standardless scheme approved in *Menton* will again apply in Alabama.

CONCLUSION

As Alabama Supreme Court Justices Houston and Maddox recognized, the Supremacy Clause of the United States Constitution should have prevented the majority of the Alabama court from adopting its own narrow standard of ERISA preemption, contrary to the intent of Congress and the great weight of federal authority. App. at 29a. The irreconcilable conflict in the application of federal law created by the majority of the Alabama court must be resolved. This Court should also grant review of the punitive damages award in this case. The impermissively excessive award resulted from a pernicious scheme devoid of meaningful standards or procedures for the protection of the property rights of civil defendants.

For all of the foregoing reasons, a writ of certiorari should issue to review the judgment and opinion of the Supreme Court of Alabama.

Respectfully submitted,

THOMAS H. NOLAN, JR.
(Counsel of Record)
VINCENT A. NOLETTO, JR.
MICHAEL S. MCGLOTHREN
WEYMAN W. MCCRANIE, JR.
BROWN, HUDGENS,
RICHARDSON, P.C.
Post Office Box 16818
Mobile, Alabama 36616
(205) 344-7744

WILLIAM H. GINSBURG
DIANA L. WINFREY
DANIEL J. YAKOUBIAN
WOOD, LUCKSINGER & EPSTEIN
1900 Avenue of the Stars
Suite 1700
Los Angeles, California 90067
(213) 557-2009

Attorneys for Petitioners

Of Counsel:
ALAN BLOOM
JOHN SOUTHWORTH
Maxicare Health Plans, Inc.
5200 West Century Boulevard
Los Angeles, California 90045

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APPENDICES

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APPENDIX A

THE STATE OF ALABAMA
JUDICIAL DEPARTMENT
THE SUPREME COURT OF ALABAMA

SPECIAL TERM, 1989

87-1100

HEALTHAMERICA and PAMELA MERLE

v.

EDWARD MENTON

Appeal from Mobile Circuit Court
(CV-86-003049)

SHORES, JUSTICE.

The plaintiff/appellee, Edward Menton, was employed as city editor for the *Mobile Press Register* newspaper ("Press Register"). As part of his employment, Menton was provided with medical insurance coverage, for which the Press Register paid 50 to 60 percent of the premiums and the balance was deducted from Menton's salary. In June 1985, the Press Register offered an alternative medical benefit selection, which allowed qualified Press Register employees either to keep the medical insurance that they had, or to cancel it and enroll in one of the two health maintenance organizations then in the Mobile area, Prime Health and defendant/appellant, HealthAmerica, without suffering an interruption of benefits.

Menton had a son, Jacob, whose premature birth necessitated a series of surgical operations to lengthen and straighten the tendons in his legs and feet. After each such operation, and after his casts were removed, Jacob would undergo physical therapy treatments three times a week until he was ready for his next surgical operation.

Menton's health insurance under the Press Register's employment benefit plan paid 80% of the cost of Jacob's physical therapy treatments and orthopedic appliances. Jacob's second operation was imminent when the Press Register employees were offered alternative coverage by either of the health maintenance organizations. HealthAmerica's list of physicians included both of the physicians who had been treating Jacob's legs; Prime Health's did not. Menton read the promotional literature regarding HealthAmerica's coverage but could not determine from that whether HealthAmerica would provide coverage for Jacob's physical therapy and orthopedic appliances.

At the suggestion of the assistant general manager of the Press Register, who had initially reviewed the coverage provided by HealthAmerica and had helped HealthAmerica distribute information about its plan to the Press Register employees, Menton attended an informational meeting of Press Register employees three days before Jacob's second surgery. This meeting was presided over by defendant/appellant Pamela Merle, who had worked for HealthAmerica for approximately one and one-half months prior to this meeting. During the meeting, the Press Register employees were repeatedly told that the coverage provided by the health maintenance organizations such as HealthAmerica and Prime Health was generally the same as, or was better than, the medical coverage that Menton and other employees had. After the meeting, Menton asked Merle specific questions about HealthAmerica's coverage of Jacob's medical expenses. He explained Jacob's medical history, his im-

pending operation, and his need for extensive physical therapy and orthopedic appliances after his second surgery. In response to a direct question from Menton, Merle informed Menton that Jacob's medical expenses would be "covered one hundred percent by HealthAmerica."

In reliance upon Merle's representations, Menton dropped his health insurance and enrolled in the HealthAmerica plan. After Menton enrolled in the HealthAmerica plan, he received a schedule of benefits in the mail. On reviewing the schedule, Menton noticed that outpatient services for physical therapy were apparently covered for only 60 days. Menton attempted to get HealthAmerica to provide the coverage that he had been promised when he dropped his previous insurance, which provided coverage for 80% of Jacob's physical therapy expenses for an unlimited period of time. HealthAmerica extended coverage for 60 additional days after the initial 60-day period, but would not provide coverage beyond that. Jacob's physical therapy expenses amounted to approximately $150 a week.

Menton filed this suit against HealthAmerica and its agent, Merle, in which he alleged a state common law action for fraud, asserting misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge, that caused him to drop the hospital coverage he had under an insured employment benefit plan and to elect the HealthAmerica coverage also provided under the plan. The defendants pleaded the general issue and preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"), 88 Stat. 829 as amended, 29 U.S.C. § 1001 *et seq.* Menton did not file a claim under ERISA. Predicated on the ERISA preemption, the defendants moved for a directed verdict at the close of Menton's case and at the close of all the evidence. The trial court observed that the Alabama Health Maintenance Organizations Statutes ("HMO Statutes"), Code

1975, §§ 27-21A-1 to 27-21A-32, and the Alabama "twisting" statute, Code 1975, § 27-12-6, might be saved by § 514(b) of ERISA if Menton's claim were subject to ERISA preemption; overruled the defendants' motions for a directed verdict; and submitted the case to the jury with instructions on Alabama civil actions for misrepresentation, without reference to the HMO statutes or the twisting statute. The jury returned a verdict in favor of Menton. After final judgment was entered, Menton filed a motion to amend his complaint to conform to the evidence, alleging a violation of § 27-12-6, the "twisting" statute. The defendants' objection to this was overruled, as was their motion for a judgment notwithstanding the verdict or in the alternative for a new trial.

The first issue presented by this case is whether ERISA preempts a state common law action for fraud where the plaintiff alleges that he relied on misrepresentations made by the defendants in dropping his old hospital insurance and electing coverage under the defendants' plan. We hold that a claim for fraud in the inducement does not "relate to" an employee benefit plan and is therefore not preempted by ERISA.

The courts in Alabama have recognized a common law right of action for fraud, at least since the case on *Einstein, Hirsch & Co. v. Marshall & Conley*, 58 Ala. 153 (1877), when Justice Stone criticized the old case of *Chandelor v. Lopus*, 1 Smith Lead. Cas. 319 (9th ed. 1889) (adjudged in the Court during the Reign of James the First), which involved alleged fraud in the sale of a stone, which the seller represented as a bezoar stone and sold as such. All the Barons, except Anderson, in the Court of Exchequer held that " 'the bare affirmation that it was a Bezoar stone, without warranting it to be so, is no cause of action; and although he knew it to be no Bezoar stone, it is not material.' " 58 Ala. at 160 (quoting *Chandelor v. Lopus*). To this Justice Stone wrote, "We submit, if this language does not sanction looser

morals than the present state of the law will justify." 58 Ala. at 160. To make certain that it did not sanction those looser morals of *Chandelor v. Lopus*, the legislature of Alabama in 1907 codified laws that it had enacted that provided civil actions for fraud (now Code 1975, § 6-5-100), for misrepresentations of material fact (now § 6-5-101), for suppression of material facts (now § 6-5-102), and for deceit (now § 6-5-103).

With ERISA, Congress imposed comprehensive federal oversight of employee benefit plans of employers engaged in interstate commerce. Under ERISA Section 502(a), as set forth in 29 U.S.C. § 1132(a)(1)(B), a civil action may be brought by a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." This limits the options of the employee, who is preempted from brigning actions under state laws when they "relate to" any employee benefit plan.

ERISA's preemption provision states:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."

29 U.S.C.A. § 1144(a).

The defendants argue that Menton is preempted under this ERISA preemption provision from filing a state common law action for fraud. Under the facts of this case, the Press Register is engaged in interstate commerce; the undisputed evidence shows that the Press Register solicits advertisements from outside Alabama, advertises for businesses located outside Alabama, and sells its papers outside Alabama. Menton was a full-time employee of the Press Register, and the Press Register had

an employee benefit plan prior to and after Menton enrolled in the HealthAmerica plan.

Therefore, we must determine whether his claim is preempted by ERISA. The defendants rely upon *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987), wherein the Supreme Court ruled that a state lawsuit asserting improper processing of a claim for benefits under an ERISA-regulated plan was preempted by federal law. In *Pilot Life* the Supreme Court held that the phrase "relate to" is to be given its "'broad common-sense meaning, such that at state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan."'" 481 U.S. at 47, citing *Metropolitan Life Insurance Co. v. Massachusetts*, infra, and *Shaw v. Delta Air Lines, Inc.*, infra.

The United States Supreme Court had considered ERISA's preemption provision three times prior to *Pilot Life*: *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1985, 68 L.Ed.2d 402 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

In *Shaw v. Delta Air Lines, Inc.*, the Court noted that "[s]ome state actions may affect employee benefits in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 100 n.21. In *Shaw*, the Court cited with approval *American Telephone & Telegraph Co. v. Merry*, 592 F.2d 118 (2d Cir. 1979), in which the Second Circuit Court of Appeals held that ERISA did not preempt a state's garnishment of a spouse's benefit plan income to enforce alimony and support orders. In accord, see, *Savings & Profit Sharing Fund of Sears Employees v. Gago*, 717 F.2d 1038 (7th Cir. 1983); *Howard v. Parisian, Inc.* 807 F. 2d 1560 (11th Cir. 1987); *Sommers Drug Stores Co.*

Employee Profit Sharing Trust v. Corrigan Enterprises, Inc., 793 F. 2d 1456 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed.2d 837 (1987).

HealthAmerica argues that *Pilot Life* forecloses debate and that Menton's claim is preempted by ERISA as one "relating to" an employee benefit plan. We disagree. *Pilot Life* involved an individual who was receiving benefits under a plan insured by the Pilot Life Insurance Company. In 1975, Everate W. Dedeaux injured his back in an accident related to his employment with Entex, Inc. Entex sponsored a long-term disability plan that qualified as an employee benefit plan under ERISA, for employees who became permanently disabled. While Entex assumed responsibility for the disability plan's day-to-day operation and administration, benefits under the plan were provided by a group insurance policy issued by Pilot Life Insurance Company.

Following Dedeaux's accident, Pilot Life provided benefits to him for two years. His benefits under the plan were first interrupted, then terminated altogether. When they were discontinued, Dedeaux sued Pilot Life. Although the complaint in *Pilot Life* contained a count for "fraud in the inducement," the opinion makes it unmistakably clear that the only claims he pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan. Justice O'Connor, writing for the Supreme Court, stated as follows:

> "Although Dedeaux's complaint pled several state common law causes of action, before this Court Dedeaux has described only one of the three counts—called 'tortious breach of contract' in the complaint, and 'the Mississippi law of bad faith' in respondent's brief—as protected from the pre-emptive effect of § 514(a). The Mississippi law of bad faith, Dedeaux

> argues, is a law 'which regulates insurance,' and thus is saved from pre-emption by § 514(b)(2)(A)."

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. at 48, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, at 48 (footnote omitted). Having considered this single count, the Court held:

> "[W]e conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and therefore is pre-empted by § 514(a)."

Id. 481 U.S. 41, at 57, 107 S.Ct. 1549 at 1558, 95 L.Ed.2d 39, at 54 (footnote omitted).

Pilot Life merely cleared the confusion that *Metropolitan Life* had created in the lower federal courts. Following *Metropolitan Life*, several lower courts held that insurance companies serving as claims review fiduciaries to fully insured employee benefit plans were subject to the full measure of state remedies, while fiduciaries of self-insured plans were not. *Pilot Life* rejected the artificial distinction between fully-insured and self-insured plans created by *Metropolitan Life*.

In this case, Menton does not claim improper processing of a claim, nor any benefits under the terms of the plan. To the contrary, he claims he was fraudulently induced to drop his existing coverage by misrepresentations made by the defendants to him prior to his becoming a member of the HealthAmerica plan. This is the clear distinction between this case and *Pilot Life*.

The Supreme Court has not drawn a hard, clear line as to which state law is preempted by § 514(a). This is demonstrated by the case of *Ft. Halifax Packing Co. v. Coyne*, 482 U.S. 1, 107 S. Ct. 2211, 96 L.Ed.2d 1 (1987), which was decided two months after *Pilot Life*. In *Ft. Halifax*, the Court held that a Maine statute requiring employers to make a one-time severance payment to employees when a plant closed was not preempted

by ERISA. The Court noted that the preemption clause expressly states that state laws are superseded to the extent that they "relate to any employee benefit plan." The Court stated that the preemption provision "does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefits plans.'" *Id.*, at 7. (Emphasis in original.) The Court observed that ERISA uses the words "benefit" and "plan" separately throughout and nowhere treats the two as synonymous. "Given the basic difference between a 'benefit' and a 'plan,' 'Congress' choice of language is significant in its pre-emption of only the latter." *Id.* at 8, 107 S. Ct. at 2216, 96 L.Ed.2d at 9 (1987).

The distinction made by the Court in *Ft. Halifax*, between laws that relate to employee benefits *plans* and laws that relate simply to employee *benefits*, is analogous to the instant case and demonstrates why Menton's claim for fraudulent inducement does not "relate to" Health-America's plan.

Teper v. Park West Galleries, Inc., 431 Mich. 202, 427 N.W. 2d 535 (1988), presented a much closer question on preemption than exists here. In that case the Michigan Supreme Court held that a plaintiff's claim against her employer for breach of an employment contract, which claimed, in part, compensation for future pension benefits, was not preempted by ERISA. The court held that "the simple fact that the damage award was based in part upon the terms of the plan does not place any fiscal or administrative burden upon the plan itself. This relationship to the plan is, in the words of the *Shaw* Court, too 'peripheral' to trigger ERISA preemption." 431 Mich. at 208, 427 N.W.2d at 541. Chief Justice Riley, concurring with the majority in *Teper*, found ERISA's definition of a "state" important for the purposes of the ERISA preemption clause:

> "Congress has further explained the scope of ERISA preemption in the definitional section, 29 U.S.C.

> § 1144(c)(2), wherein the term 'state' for preemption purposes is characterized as 'a State, any political subdivision thereof, or any agency or instrumentality of either, *which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.*' "

431 Mich. at 212, 427 N.W.2d at 545 (emphasis in original).

In *Quigley v. UNUM Life Ins. Co.*, 688 F. Supp. 80 (D. Mass. 1988), the plaintiff's decedent was a participant in a retirement pension plan. Plaintiff's decedent received eight years' of monthly annunity payments following his retirement. Following his death, his estate brought an action against UNUM for breach of contract and misrepresentation. UNUM contended that the claims were preempted by ERISA. The federal district court rejected UNUM's preemption argument, finding that the plaintiff's causes of action were "so tenuously related to an ERISA plan that the claims are not preempted." *Id.*, at 82. In so holding the court found:

> "The dispute in this case does not involve the plan and the plaintiffs do not claim that any term of the pension plan was violated. . . . Litigation of these issues will not, in effect, result in state regulation of the pension plans contrary to the purposes of ERISA. The concern which motivated the enactment of the ERISA preemption provisions, the threat of inconsistent and conflicting state regulations of ERISA plans, is not implicated if this action is allowed to go forward. *See Ft. Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 107 S. Ct. 2211, 2216, 96 L. Ed. 2d 1 (1987)."

Id., at 82-83.

In *Greenblatt v. Budd Co.*, 666 F. Supp. 735 (E.D. Pa. 1987), the plaintiff sued his employer for misrepresenting to him that the benefits he was receiving under one of

two pension plans would be made equal to those available under the other plan. The Court, after first acknowledging that the Supreme Court has determined that "Congress made the preemption provision 'deliberately expansive' and 'designed to "establish pension plan regulation exclusively as a federal concern,"'" *id.*, at 741, quoting *Pilot Life*, rejected the employer's argument that ERISA preempted the plaintiff's claim:

> "The cause of action for misrepresentation alleged by the plaintiff at Count II of his complaint should not be preempted because, simply put, the premise underlying this action was that plaintiff was deceived by the verbal statements made and the actions taken by his employer. That the subject of the deception concerned pension benefits is only incidental and not essential to the plaintiff's cause of action. Like promises for a raise in salary, a promotion, or the use of tickets to a baseball game, plaintiff's employer's promise to provide the plaintiff with certain benefits at some unknown time in the future, upon which the plaintiff could reasonably rely, is the essence of the fraud alleged."

Id., at 742. In accord: *Morningstar v. Meijer, Inc.*, 662 F. Supp. 555 (E.D. Mich. 1987) (plaintiff's claim for breach of employment contract against former employer did not "relate to" ERISA plan, despite the fact that plaintiff claimed as part of her damages the value of certain future fringe benefits under an ERISA plan); *McNamee v. Bethlehem Steel Corp.*, 692 F. Supp. 1477 (E.D. N.Y. 1988) (plaintiff claimed fraudulent misrepresentation by employer that upon rehiring he would suffer no break in pension coverage, and court found that because plaintiff's claims did not "seek benefits under the plan" his claim was not preempted).

Courts nationwide continue to struggle with ERISA preemption issues occasioned by the "relate to" language in Section 514(a). See: *Springer v. Wal-Mart Assoc.*

Group Health Plan, [No. 88-AR-5226, June 6, 1989] —— F. Supp. —— (N.D. Ala. 1989); *Amos v. Blue Cross-Blue Shield of Alabama*, 681 F. Supp. 1515 (N.D. Ala. 1988), rev'd, 868 F.2d 430 (11th Cir. 1989); *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988); *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987); *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822 (N.D. Ala. 1988); *Graves v. Blue Cross of California*, 688 F. Supp. 1405 (N.D. Cal. 1988); *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. ——, 108 S. Ct. 2182, 100 L. Ed.2d 836 (1988); *Board of Trustees of Cedar Rapids Pediatric Clinic, P.A., Pension Plan v. Continental Assurance Co.*, 690 F. Supp. 792 (W.D. Ark. 1988); *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989); *Idaho Plumbers and Pipefitters Health and Welfare Fund v. United Mechanical Contractors, Inc.*, 875 F.2d 212 (9th Cir. 1989); *Totton v. New York Life Ins. Co.*, 685 F. Supp. 27 (D. Conn. 1987); *Tesch v. General Motors Corp.*, 685 F. Supp. 1084 (E.D. Wis. 1988); *Southern California Meat Cutters Unions & Food Employers Pension Trust Fund v. Investors Research Co.*, 687 F. Supp. 506 (C.D. Cal. 1988); *Hall v. Pennwalt Group Comprehensive Medical Expense Benefits Plan*, (E.D. Pa. 1989); *Schultz v. Boesken Elec. Co.*, 703 F. Supp. 656 (S.D. Ohio 1988); *Urban Health Services, Ltd. v. Travelers Ins. Co.*, 703 F. Supp. 53 (N.D. Ill. 1989); *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989); *Seafarers' Welfare Plan v. Dixon*, 512 So. 2d 53 (Ala. 1987); *Davidian v. Southern California Meat Cutters Union & Food Employees Benefit Fund*, 859 F. 2d 134 (9th Cir. 1988); *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988); *Landy v. Travelers Ins. Co.*, 530 So. 2d 214 (Ala. 1988); *Massachusetts v. Morash*, 490 U.S. ——, 109 S.Ct. 1668, 104 L.Ed.2d 98, (Mass. 1989). Although there is authority on both sides, the better reasoned cases, and those which

recognize the dual role of state and federal law after ERISA, have reached the conclusion that we have reached today.

Authors Kilberg and Inman in their Observations, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex.L. Rev., at 1328-30 (1984), suggest that the Act contemplates a different approach to these cases. They argue, and we agree, that the Act itself provides a better formula for discerning which state cases are preempted and which are not:

> "Although the courts often have turned to the 'indirectly' language of section 514(c)(2) in their analysis, they have largely ignored another critical word contained in the same clause. Section 514(c)(2) defines a 'State' as an entity that '*purports* to regulate, directly or indirectly, the terms and conditions' of the plan.
>
> "An inquiry into the significance of the word 'purports' sheds considerable light on the elusive 'relate to' language of section 514(a). 'Purport' has two ordinary meanings: 'to . . . imply or profess outwardly' and 'to have in mind.' Both meanings comprehend purpose—the first speaks to apparent purpose, the second to actual purpose or intent. In the state law context, an apparent purpose to regulate, manifested by a reference to employee benefit plans in the text of the law, invariably reflects an actual regulatory purpose. Hence, any law expressly directed toward employee benefit plans 'purports' to regulate the plans within the meaning of section 514.
>
> "Congress meant to preempt such state laws, however, whether or not they are styled as employee benefit plan regulations. In light of this congressional intent, 'purports' must be construed in its 'normal sense' of 'to have in mind.' This construc-

tion necessitates an inquiry into the actual legislative or judicial purpose underlying the state law in question. To determine whether the purpose of a state law is to regulate benefit plans, a court should identify what the law seeks to accomplish and ask whether the law presupposes the existence of benefit plans to achieve that aim. If the purpose of the law is to affect the terms and conditions of employee benefit plans, the law may be found to 'relate to' the plans under section 514 (a). If such a purpose is absent, the 'relate to' requirement will not be met and the law will not be preempted, even though it may have some tangible effect on benefit plans.

"This purpose-effect distinction serves well to identify those state 'legislative' laws that Congress intended to preempt with section 514. In addition, this approach is useful in determining whether section 514 preempts a state court or agency application of an otherwise valid state law to a benefit plan. In these adjudicative settings, a second 'State Law' emerges that seeks to impose a provision of state law on the plan irrespective of the plan's terms. Such state adjudications invariably 'purport' to regulate the plan and consequently should be preempted under section 514(a). State adjudicative decisions raise a different issue, however, when the decisions are grounded in the terms of the plan itself, rather than in the terms of the state law applied to the benefit plan. The question then arises whether this act of interepresentation itself constitutes a state law that 'relates to' the plan. This problem is treated in the following subpart.

"Section 502(a)(1)(b) provides that a participant or beneficiary of a plan may bring a civil action 'to recover benefits due to him *under the terms* of his plan, to enforce his rights *under the terms* of the plan, or to clarify his rights to future benefits

under the terms of the plan. . . .' Section 502(e)(1) provides that this civil action may be brought in either federal or state court. To reconcile this grant of concurrent jurisdiction with section 514's preemption of state laws that regulate the terms and conditions of a plan, state court decisions that merely interpret the terms of the plan in order to adjudicate the rights of a participant or beneficiary must be deemed not to regulate the plan's terms and conditions. Any other conclusion would reduce the grant of concurrent jurisdiction to surplusage: decisions sanctioned by sections 502(a)(1)(B) and 502(e)(1) would be preempted by section 514.

"Thus, the jurisdictional sections of ERISA, by allocating authority to the state courts to interpret the terms of a plan, imply that interpretation alone does not constitute regulation of the terms and conditions of a plan. If interpretation is not regulation of the plan's terms when federal and state courts have concurrent jurisdiction, there is no basis for a different conclusion when the state court interprets the terms of a plan in a case over which only the state court has jurisdiction. Thus, although the states are barred from regulating employee benefit plans, they are invited to construe the plans' terms, a task that often entails construing ERISA's requirements. The states can, therefore, create decisional law, but they may not apply existing state law, decisional or otherwise, that overrides the terms of the plan."

Neither Alabama's fraud statute nor the common law action for fraud purports to regulate, directly or indirectly, the terms and conditions of a plan, and the application of Alabama's fraud law to the facts of this case does not relate to or affect the administration of the plan.

The analysis suggested by Kilberg and Inman would promote the policy endorsed by the United States Supreme Court in *Ft. Halifax*: "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of government authority preserved in our federalist system.'" 482 U.S. at ——, quoting *Alessi v. Raybestos-Manhattan, Inc., supra.* It is equally consistent with the Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, where the Court stated: "We must also presume that Congress did not intend to preempt areas of traditional state regulation." 471 U.S. at 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

The defendants argue that the trial court erred in allowing Menton to amend his complaint after final judgment was entered, to allege a violation of the "twisting" statute, § 27-12-6. The trial court did not err, for two reasons. The first is that every element underlying the "twisting" statute is included in the plaintiff's complaint stating a common law cause of action for fraud, now codified at § 6-5-101 (misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge). Therefore, the amendment to the complaint alleging violation of § 27-12-6 was redundant, and it could not have prejudiced the defendants in any way. Second, if it is assumed for purposes of argument, or if some other court decides that a claim under § 6-5-101 or its common law counterpart is preempted by section 514(a) of ERISA, then we would hold that a claim under § 27-16-6 could still be maintained under the saving clause of ERISA as a state law regulating the business of insurance:

> "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ."

Section 514(b)(2)(b), 29 U.S.C. § 1144(b)(2)(A).

The purpose of Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") of the Alabama Code is expressed in § 27-12-1(a):

> "The purpose of this chapter is to regulate trade practices *in the business of insurance* in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." (Emphasis added.)

Section 27-12-6 ("Twisting") provides as follows:

> "No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy."

Section 27-1-2(3) defines "person" for the purposes of Title 27 as follows:

> "An individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity."

The United States Supreme Court in *Pilot Life* looked to "common sense" and to the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in interpreting the saving clause, and in doing so it used the following criteria to determine whether a practice falls under the "business of insurance":

> "'[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

Pilot Life, 481 U.S. at 48, 107 S. Ct. at 1553-54, 95 L.Ed.2d at 48 (1987) (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.W. 119, 129 (1982)). The legislature of Alabama, in adopting the "twisting" statute § 27-16-6, has enacted a fraud and misrepresentation statute that specifically relates to the insurance industry and, therefore, we believe it is "saved" from preemption by a proper interpretation of § 514(b).

We acknowledge that the Eleventh Circuit Court of Appeals has held in *Farlow v. Union Cen. Life Ins. Co.*, [No. 88-7513, June 6, 1989] —— F.2d —— (1989), that the Alabama "twisting" statute does not create a private cause of action and that, if it did, a claim under it would be preempted under ERISA if the employer's conduct giving rise to the claim was not "wholly remote in content" from the benefit plan. Presumably, under this holding, the commissioner of insurance would be preempted from imposing the statutory sanctions against insurance companies that violate § 27-12-1 et seq. We are unconvinced that Congress intended this result.

We recognize that the cases from the various federal courts are disparate. We adopt the position taken by the Sixth Circuit on the precise issue involved in this case: fraud in the inducement. *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989). In that case, the plaintiffs alleged that the defendant had fraudulently induced them to participate in a plan covered by ERISA. The defendants claimed preemption under § 514(a). The district court held that "preemption by ERISA applies only once the benefit plan is in existence" and does not

apply to alleged common law actions of fraud or misrepresentation "to get the plaintiffs to join the plan." Because the purported misconduct of P*I*E occurred before the plaintiffs became participants or beneficiaries, and because they were not suing for benefits under the plan, the district court had held that preemption did not apply. In accord, *Butler v. Fringe Benefits Plan, Inc.*, 701 F.Supp. 804 (N.D. Ala. 1988).

The Circuit Court of Appeals for the Sixth Circuit affirmed, citing *Miller v. Lay Trucking Co.*, 606 F.Supp. 1326 (N.D. Ind. 1985) (holding that the plaintiff's common law action for fraudulent inducement was not preempted by ERISA because the fraud occurred prior to the time the plaintiff entered the plan, and because the fraud claim did not directly affect the regulation of the ERISA plan).

The Sixth Circuit acknowledged, as we do, that there is respectable authority for the positions taken by both sides concerning preemption of state common law claims of fraud, etc.[1] It adopted in *Perry* the position expressed in *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 986, 102 S.Ct. 512, 70 L.Ed. 2d 384 (1981), that preemption should apply to a state law claim only if Congress has provided a remedy for the wrong or wrongs asserted.

Congress has not provided a remedy for the wrong asserted by Mr. Menton, and we are loath to imply an intent on its part to do so.

We next address the defendants' contention that the trial court erred in denying the defendants' motion for a

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[1] *Cefalu v. B. F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1989); *Cantrell v. Great Republic Ins. Co.*, 873 F.2d 1249 (9th Cir. 1989); *Straub v. Western Union Telegraph Co.*, 851 F.2d 1262 (10th Cir. 1988); *Hermann Hosp. v. Meba Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988).

mistrial based upon alleged improper argument by plaintiff's counsel. The defendants claim that the plaintiff's counsel improperly aroused the passion and prejudice of the jury against the defendants. The plaintiff claims that the jury verdict is the result of the overwhelming evidence of fraud, cover-up, and conspicuously selective memories that was introduced at the trial of the case. We have repeatedly held that in fraud actions "great latitude is allowed in the scope of evidence introduced." *Simmons Mach. Co. v. M & M Brokerage, Inc.*, 409 So.2d 743, 756 (Ala. 1981). The reason for allowing such latitude is that the perpetrator of a fraud is often the sole possessor of the actual knowledge of fraud. *Sessions Co. v. Turner*, 493 So.2d 1387, 1391 (Ala. 1986).

Questions of materiality, relevancy, and remoteness of evidence are matters resting within the discretion of the trial court, whose exercise of that discretion will not be reversed unless it has been grossly abused. *Dorcal, Inc. v. Xerox Corp.*, 398 So.2d 665, 670-71 (Ala. 1981). This discretion extends to argument of counsel. We have said:

> "The control of arguments rests largely in the discretion of the trial court, before whom the argument is made, and who sees and can judge the demeanor of the counsel making the argument, and who can determine whether a prejudicial atmosphere is created by such remarks; therefore, we will not interfere where this discretion is not abused."

Southern Ry. Co. v. Jarvis, 266 Ala. 440 at 446, 97 So.2d 549 (1957), in accord, *Old Southern Life Ins. Co. v. Woodall*, 348 So.2d 1377 (Ala. 1977).

Counsel may state or comment upon all evidence admitted at trial and draw inferences and conclusions from that evidence. *Seaboard Coastline R. R. v. Moore*, 479 So.2d 1131 (Ala. 1985). This Court has established a standard of review on claims for improper argument whereby we will not reverse unless substantial prejudice

has resulted. *Id.*, at 1136. In denying defendants' motion for a JNOV, new trial, and remittitur, the trial court stated: "[T]he court cannot call to mind [nor] have the attorneys for the defendants shown to the court any factor at all that could be construed to indicate bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury."

We recently affirmed a trial court's refusal to grant a mistrial, under circumstances similar to the present case, in which there was a reference to the wealth of the defendants. We observed that the court heard the remark in context, witnessed the effect upon the jury, and was able to make a better judgment than we were as to whether the remark was improper argument and might have prejudiced the jury. *L. W. Johnson & Assoc., Inc. v. Rivers Construction Co.*, 532 So.2d 618 at 625 (Ala. 1988). We have carefully examined the record in this case and find no error by the trial judge, who had the opportunity to judge the demeanor of counsel and who could determine whether his remarks created a prejudicial atmosphere.

The defendants also claim that the trial court erred in charging the jury. The jury asked: "Are the defendants 'the corp. and Pam' or 'the corp. or Pam?' " The judge replied:

> "THE COURT: Well, for your purposes it doesn't make any difference. I mean the corporation is fully responsible for the acts of its agents, so it dosen't make any difference. I mean, you know, we're concerned—you know, the representations are the representations of the agent. I mean, I don't think I—is that—
>
> "JUROR: That's what we needed to know."

Defendants admit that the trial court correctly instructed the jury that a corporation is responsible for the acts of its agents. We find no error in so instructing the jury.

Defendants contend that the trial court erred in refusing to submit special verdict questions to the jury and in charging the jury as to reckless fraud. Under Rule 49, Ala. R. Civ. P., the use of a special verdict is within the sound discretion of the trial court. After instructing the jury on willful misrepresentation, based on the *Alabama Pattern Jury Instructions*, the trial court charged the jury on the definition of reckless misrepresentation as follows:

> "A reckless misrepresentation which is also actionable [sic]; the law says that if you are reasonably satisfied from the evidence that the defendant misrepresented a material fact recklessly without knowledge of the truth or the falsity thereof and with the intent to induce the plaintiff to act and that the plaintiff acted upon said reckless misrepresentation to his injury, then the defendant is also guilty of a legal fraud under those circumstances.
>
> "If the plaintiff has not proved the case of fraud through either an intentional or a reckless misrepresentation as I just described to you, you would go no further. Your verdict would be for the defendant." [R. 295-96.]

One of the Alabama pattern jury instructions defines "reckless misrepresentation" as follows:

> "If you are reasonably satisfied from the evidence that the defendant misrepresented a material fact recklessly without knowledge of the truth or falsity thereof and with the intent to induce plaintiff to act and that plaintiff acted upon said reckless misrepresentation to his injury, then defendant is guilty of a legal fraud."

Alabama Pattern Jury Instructions (Civil), Instruction 18.02, p. 270.

During jury deliberations, the jury had a question. The trial court asked the foreman: "You want me to define

a reckless misrepresentation?" The foreman replied: "Yes, Sir." To this the trial judge responded:

> "If you are reasonably satisfied from the evidence that the defendants misrepresented a material fact recklessly without knowledge of the truth or falsity and with the intent to induce the plaintiff to act, and the plaintiff did act upon the reckless misrepresentation to his injury, then the defendant is guilty of a legal fraud." [R. 306]

The trial court gave the identical definition of reckless misrepresentation both during his oral charge and after the jury's question. In doing so, he correctly charged the jury.

The defendants also contend that the court's charge on punitive damages in a fraud case constitutes reversible error. The longstanding rule of this Court is as follows:

> "[P]unitive damages may be recovered in a fraud action if the fraudulent misrepresentation was malicious, oppressive, or gross, or made with knowledge of its falsity or so recklessly as to amount to the same thing or was made with the purpose of injuring the plaintiff."

Curry Motor Co. v. Hasty, 505 So.2d 347 (Ala. 1987). See: *Morgan v. South Central Bell Telephone Co.*, 466 So.2d 107 (Ala. 1985).

In the present case, the trial judge instructed the jury in his oral charge as follows:

> "[T]he law says that you are authorized to award punitive damages in a fraud action if it is shown to your reasonable satisfaction from the evidence that the fraud was malicious, oppressive, or gross, or a misrepresentation was made with the knowledge of its falseness or so recklessly done as to amount to

> the same thing and committed with the intent to injure and to defraud." [R. 296-97.]

The jury had a question on the meaning of reckless fraud during its deliberations. The trial court further instructed the jury as follows:

> "I just want to clarify one thing, ladies and gentlemen, I want to clarify this: the definition I just read to you would authorize if the plaintiff proved it, to recover actual damages. With respect to recovering punitive damage, the law says that the fraud must be malicious, oppressive or gross or made with knowledge of the falseness of the representation or so recklessly done as to amount to the same thing and committed with the intent to injure and defraud."

The trial court did not err in charging the jury.

The defendants argue that the trial court erred in denying their motions for directed verdict, judgment notwithstanding the verdict, and a new trial based upon the insufficiency of the evidence or either intentional or reckless fraud. We have carefully reviewed the record in this case. The record supports the decision of the trial judge.

The defendants argue that the award of punitive damages violates the Constitution of Alabama and the Constitution of the United States of America. They argue that the jury verdict of $1,797,588 in punitive damages is based upon only $2,412 in compensatory damages. However, the defendants did not raise any constitutional question prior to filing their motion for judgment notwithstanding the verdict, or, in the alternative, for a new trial or for a remittitur. Although the trial judge, in his order of June 13, 1988, states that the defendants' challenges to the constitutionality of the award of punitive damages "were timely raised and effectively

presented," in fact, these issues were not raised until 29 days after the trial court had entered judgment on the jury's verdict.

It is settled law that constitutional issues must be raised before the trial court in order to be preserved for review upon appeal. *Marion v. Hall*, 429 So.2d 937 (Ala. 1983); *Talley v. A & M Construction Co.*, 284 Ala. 371, 373, 225 So.2d 359, 360 (1969), *cert. denied*, 397 U.S. 995, 90 S.Ct. 1133, 25 L.Ed.2d 402 (1970); *Hicks v. Huggins*, 405 So.2d 1324 (Ala. Civ. App.), *cert. denied*, 405 So.2d 1328 (Ala. 1981). We have declined previously to consider similar issues because "these challenges were not presented for resolution before the trial court and [were] presented for the first time on appeal." *Nationwide Mutual Ins. Co. v. Clay*, 525 So.2d 1339, 1344 (Ala. 1987), *cert. denied*, —— U.S. ——, 109 S. Ct. 863, 102 L.Ed.2d 988 (1989). Thus, the defendants did not preserve their constitutional issues for appeal. However, we would be remiss if we neglected to note that the United States Supreme Court has recently ruled in the case of *Browning-Ferris Industries of Vermont, Inc. v. Kelco Disposal, Inc.*, [No. 88-556, June 26, 1989] —— U.S. —— (1989) that the excessive fines clause of the Eighth Amendment does not apply to punitive damages awards in cases between private parties. In doing so, the Supreme Court upheld an award of $6 million in punitive damages when the compensatory damages were $51,146.

Finally, the defendants claim that the verdict of the trial court was excessive and should be set aside.

With respect to the question of a remittitur, it is within the authority of this Court to order a remittitur, pursuant to *Code of Alabama* (1975), § 12-33-71, if it finds the judgment to be excessive. The rules that govern this Court's review of a verdict claimed to be excessive were set out in *Vest v. Gay*, 275 Ala. 286, 154 So.2d 297 (1963):

> " 'The rules governing our consideration of this question are clear and have been reiterated quite often. We refer to them briefly for emphasis: The verdict of a jury should not be interfered with merely because in the opinion of the court the jury gave too little or too much . . .; and the authority vested in the courts to disturb a verdict of the jury on the ground of excessive damages is one which should be exercised with great caution . . .; where there is no set standard for the admeasurement of the damages but the damages to be awarded are left to the sound discretion of the jury, a remittitur or a new trial should not be ordered on the ground of excessiveness of the jury's verdict except in those cases where the court can clearly see that the verdict has been reached on account of bias, passion, prejudice, corruption, or other improper motive or cause . . .; but where the damages allowed are so excessive as to warrant the belief that the jury must have been misled by some mistaken view of the merits of the case the court may interfere and set the verdict aside . . .; also, where the trial court refuses to grant a new trial because [it] does not believe the verdict to be excessive, the favorable presumption attending the jury's verdict is thereby strengthened. . . .' "

(As quoted in *Black Belt Wood Co., Inc. v. Sessions*, 514 So.2d 1249, at 1264-65 (Ala. 1986).)

The trial court issued an order denying defendants' motion for a remittitur, and in it the trial judge expressly acknowledged that he had carefully considered all of the evidence on all issues. The trial judge noted that a remittitur or new trial is proper "where the court can clearly see that the verdict is tainted by bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury." The trial judge stated in his order as follows:

"The Court has carefully considered all of the evidence in the case on all issues. The Court has carefully considered the nature and quality of the testimony of all of the witnesses, as well as the demeanor of each witness while testifying. The Court has further reviewed its Charge to the jury on the issue of damages and has found that it correctly instructed the jury on damages. As a part of the charge, the jury was instructed that if they found in favor of the Plaintiff, Edward Menton, and against the Defendants, HealthAmerica and Pamela Merle, that in assessing damages they should take into consideration and give due regard to the enormity of the wrong and the necessity of preventing similar wrongs in the future.

"After a careful review by the Court of the entire trial of the case, including the testimony of all of the witnesses, all of the documentary and demonstrative evidence produced at trial, the Court's observation of all parties and witnesses, and the Court's charge to the jury on damages, the Court is convinced that the jury carefully and conscientiously followed the Court's instructions in assessing damages in the case at $1,800,000.00 and that the award is consistent with the Court's instructions and supported by the evidence.

"This Court finds, after a review of the entire trial, that the central issue presented in the Defendant's motion for remittitur is whether or not the jury verdict of $1,800,000.00 in this case is, in and of itself, evidence of bias, passion, prejudice, corruption or other improper motive or cause. The Court cannot call to mind [nor] have the attorneys for the Defendants shown to the Court any factor at all that could be construed to indicate bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury. On the contrary, the Court

finds that there was clear and convincing evidence of fraud on the part of the Defendants, HealthAmerica and Pamela Merle, which in the Court's opinion fully justified the jury's verdict.

"The Court finds that the $1,800,00.00 verdict is not excessive and is not the result of bias, passion, prejudice, corruption, or other improper motive or cause."

We have reviewed this order of the trial judge, and we find that he followed the guidelines we have previously adopted to be used by a trial court in reviewing judgments. *Hammond v. City of Gadsden*, 493 So.2d 1374 (Ala. 1986); *Harmon v. Motors Ins. Corp.*, 493 So.2d 1370 (Ala. 1986); *Alabama Farm Bureau Mutual Cas. Ins. Co. v. Griffin*, 493 So.2d 1379 (Ala. 1986). The trial judge applied the principles of law adopted in those cases, held a hearing, and set forth the reasons why he felt that the law did not authorize him to order a remittitur.

We have examined the record in the light of our rules as to remittitur. We are of the opinion that the judgment of the trial court, including the damages award, which the trial court reviewed on motion for JNOV, for a new trial, and for remittitur, is due to be, and it is hereby is, affirmed.

AFFIRMED.

Hornsby, C. J., and Jones, Adams, Steagall, and Kennedy, JJ., concur.

Maddox and Houston, JJ., dissent, with opinion by Houston, J.

HOUSTON, JUSTICE (dissenting).

The second paragraph in Article VI, of the Constitution of the United States, provides:

> "*This Constitution, and the laws of the United States which shall be made in pursuance thereof*; and all treaties made, or which shall be made, under the authority of the United States, shall be *the supreme law of the land; and the judges in every state shall be bound thereby, any thing in the Constitution or laws of any state to the contrary notwithstanding.*" (Emphasis supplied.)

If I were writing on a clean slate, freed from the deference that I do and must give to the opinions of the United States Supreme Court, I could reach the *result* reached by the majority of this Court in this case, on the preemption issue, for I would adopt the "purpose-effect" and "regulation-interpretation" distinctions suggested as an alternative approach to the "relate to" requirement by William J. Kilberg's and Paul D. Inman's article *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex.L. Rev. 1313, 1328-30 (1984). However, I have given my solemn oath to uphold the Constitution of the United States, and that includes the second paragraph of Article VI; therefore, I must dissent.

Justice O'Connor, in delivering the opinion for a unanimous Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 44-46, 107 S.Ct. 1549, 1551-52 (1987), wrote:

> "In ERISA, Congress set out to
>
> > "'protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for

> fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.' § 2, as set forth in 29 U.S.C. § 1001(b).

"ERISA comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability or death. § 3(1), 29 U.S.C. § 1002(1).

"Congress capped off the massive undertaking of ERISA with three provisions relating to the pre-emptive effect of the federal legislation:

> " 'Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .' § 514(a), as set-forth in 29 U.S.C. § 1144(a) (pre-emption clause).
>
> " '. . . .'

". . . .

" '[T]he question whether a certain state action is pre-empted by federal law is one of congressional intent. " 'The purpose of Congress is the ultimate touchstone.' " ' *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208, 105 S.Ct. 1904, 1909, 85 L.Ed.2d 206 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504, 98 S.Ct. 1185, 1189, 55 L.Ed.2d 443 (1978), quoting *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103, 84 S.Ct. 219, 222, 11 L.Ed.2d 179 (1963). We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and *designed to 'establish pension plan regulation as exclusively a federal concern.' Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504,

523, 101 S.Ct. 1895, 1906, 68 L.Ed.2d 402 (1981). As we explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983):

> "'The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R.Conf.Rep. No. 93-1280, p. 383 (1974); S.Conf.Rep. No. 93-1090, p. 383 (1974).'" (Emphasis supplied.)

In Kilberg and Inman's *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex.L.Rev. 1313, 1315-16, the following appears:

> "Express preemption provisions such as section 514 must be distinguished from the implied preemption that arises from the supersession inherent in antithetical federal and state commands or from the encroachment of state law into a field occupied by comprehensive federal regulation or interests. To strike down a state law in an implied preemption case, the court must find either a specific conflict between federal and state commands for a clash between zones of sovereign interest. The goal of an implicit preemption analysis should be to accommodate the federal interest with the least possible displacement of state law. *The goals of an express preemption analysis, in contrast, should be to prevent subtle or incremental state encroachment into a field that Congress has chosen expressly to reserve for federal law.* Yet, courts have mistakenly applied preemption doctrines fashioned in implied preemption cases to section 514 cases, in which the issue is

whether the federal law—by its express terms—preempts the state law in question. *Once Congress has declared its express intent to preempt or to save a state law, it has largely obviated judicial inquiry into considerations other than those concerning the text of the preemption provision.*" (Emphasis supplied.)

"[A]ny and all State laws insofar as they may now or hereafter relate to any employee benefit plan," subject to certain exceptions that will be discussed later, is what Congress expressly preempted. 29 U.S.C. § 1144 (a). "The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law. . . ." 29 U.S.C. § 1144(c). Does this preempt a civil action by Menton, who is a "participant" (29 U.S.C. § 1002(7)) and a "party in interest" (29 U.S.C. § 1002 (14)) for an intentional or reckless misrepresentation by HealthAmerica, which is a "party in interest" (29 U.S.C. § 1002 (14)) as to the medical coverage benefits provided by a particular employee benefit plan?

Medical coverage benefits are benefits that "accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of [Menton];" therefore, they are "risks that ERISA is intended to address," *Massachusetts v. Morash*, —— U.S. ——, 109 S.Ct. 1668, 1669 (1989). Likewise, the phrase "relate to" has been given its broad commonsense meaning, so that a state law relates to an employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines*, 463 U.S. 85, 97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985); *Pilot Life Ins. Co. v. Dedeaux*, supra. In this case, the representation was made by a party in interest as to an employee benefit plan to a party in interest as to that same employee benefit plan concerning medical benefits payable under that employee

benefit plan. Clearly, the representation related to the employee benefit plan, as "related to" is defined by the United States Supreme Court.

In *Pilot Life Ins. Co. v. Dedeaux*, supra, Dedeaux's complaint contained three counts: " 'tortious breach of contract' "; " 'breach of fiduciary duties': "; and " '*fraud in the inducement.*' " (Emphasis supplied.) 481 U.S. at 43, 107 S.Ct. at 1551. At the close of discovery, Pilot Life moved for summary judgment, arguing ERISA preemption. The district court entered summary judgment; the Court of Appeals for the Fifth Circuit reversed; the United States Supreme Court granted certiorari and reversed the Fifth Circuit and reinstated the summary judgment for Pilot Life. In *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), the Eleventh Circuit Court of Appeals held that Alabama state law claims of bad faith and fraud (which a review of the amended complaint in *Belasco* shows to be remarkably similar to the fraud alleged in the case at issue) of a plaintiff, who was a "participant" and a "party in interest" as to an employee benefit plan against an insurance company that was a "party in interest" as to that employee benefit plan related to the plan and were preempted.

The facts in *Davidian v. Southern California Meat Cutters Union & Food Employees Benefits Fund*, 859 F.2d 134 (9th Cir. 1988), are similar to the facts in the case at issue. Davidian, a "participant" and "party in interest" as to an employee benefit plan, alleged that he was planning to retire and that the plan gave him a choice of one of three benefits programs. A "party in interest" as to the plan described the third option as paying "approximately 80%" of major medical coverage, like plaintiff's prior coverage, but did not inform the plaintiff that, unlike his prior coverage, reimbursement for major medical expenses under the third option was capped at $20,000.00. The plaintiff enrolled in the third option and

subsequently underwent heart surgery. The plan refused to pay plaintiff's medical expenses in excess of $20,000.00. Davidian filed suit against the plan for fraud and deceit. The Ninth Circuit held that Davidian's claims were preempted and addressed Davidian's contention that claims for future benefits, as distinguished from past benefits, are not preempted, as follows:

> "There is no reason for such a distinction based on the purpose of the preemption provisions of the Act. The potential for conflicting and inconsistent state and local regulation of employee benefit plans is as real whether past or future benefits are involved."

859 F.2d at 135.

This Court held that the bad faith refusal to pay insurance benefits under an employee benefit plan by a party in interest as to an employee benefit plan to a party in interest as to that same employee benefit plan did not relate to the plan and was not preempted by ERISA. *Hood v. Prudential Ins. Co. of America*, 460 So.2d 1227 (Ala. 1984). After the United States Supreme Court decided *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), and *Pilot Life Ins. Co. v. Dedeaux, supra*, we reversed ourselves and held that Hood's bad faith claim was preempted. *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988). Having had our judicial flexibility rendered rather rigid by our federalist system, we have ruled in favor of ERISA preemption of common law causes of action. See, *Landy v. Travelers Insurance Co.*, 530 So.2d 214 (Ala. 1988); *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988); and *Seafarers' Welfare Plan v. Dixon*, 512 So.2d 53 (Ala. 1987).

Justice O'Connor in *Pilot Life*, supra, wrote:

> "The Solicitor General, for the United States as *amicus curiae*, argues that Congress clearly expressed an intent that the civil enforcement provisions of

ERISA § 502(a) be the *exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits*, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstable to the purposes and objectives of Congress. *Brief for United States as Amicus Curiae* 18-19. We agree. The conclusion that § 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of § 502(a) was modeled on the exclusive remedy provided by § 301 of the Labor-Management Relations Act (LMRA), 61 Stat. 156, 29 U.S.C. § 185.

"The civil enforcement scheme of § 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA. The civil enforcement scheme is sandwiched between two other ERISA provisions relevant to enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan. Section 501, 29 U.S.C. § 1131, authorizes criminal penalties for violations of the reporting and disclosure provisions of ERISA. Section 503, 29 U.S.C. § 1133, requires every employee benefit plan to comply with Department of Labor regulations on giving notice to any participant or beneficiary whose claim for benefits has been denied, and affording a reasonable opportunity for review of the decision denying the claim."

481 U.S. at 52-53, 107 S.Ct. at 1555-1556. (Emphasis supplied.)

In view of this policy, I cannot see how civil actions for bad faith in processing claims for benefits under ERISA plans are preempted and civil actions for misrepresentations made by a "party in interest" to a "party in interest/participant" concerning the coverage under

ERISA plans are not, and, indeed, they have been so pre-empted in most cases since *Pilot Life*, supra. See, i.e., *Pilot Life* (fraud in the inducement); *Belasco* (misrepresentation of benefits payable under an ERISA plan); *Davidian* (misrepresentation of benefits payable under an ERISA plan). I have studied all of the cases cited in the majority opinion, in briefs, and at oral argument by the parties, and I do not believe that an analysis of each case would be helpful to the bench or bar. Contrary to what the majority contends, I believe that the weight of authority of cases decided since *Pilot Life*, supra, supports my conclusion.

Reluctantly, I would hold Menton's claim to be related to the Press Register's employee benefit plan and pre-empted by ERISA on authority of *Shaw v. Delta Air Lines*, supra; *Metropolitan Life Ins. Co. v. Massachusetts*, supra; *Pilot Life Ins. Co. v. Dedeaux*, supra; *Belasco v. W.K.P. Wilson & Sons, Inc.*, supra; and *Davidian v. Southern California Meat Cutters Union & Food Employees Benefits Fund*, supra.

I am not persuaded that civil actions for bad faith or fraud have anything to do with regulation of employee benefit plans or that the purpose for such actions is to affect the terms and conditions of employee benefit plans. However, I believe that this has been decided otherwise by a higher court; and I cannot justify holding that Menton's cause of action does not "relate to" an employee benefit plan in order to save it from pre-emption, when the causes of action asserted in *Pilot Life*, supra, for tortious breach of contract and fraud in the inducement and the causes of action asserted in *Belasco*, supra, for bad faith and fraud were held to "relate to" employee benefit plans and therefore to be preempted. To so hold would be to make a distinction without a difference.

Is Menton's cause of action exempted from preemption under 29 U.S.C. § 1144(b)(2)(A)? That statute reads:

"[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ."

The trial court indicated that it was not granting HealthAmerica's and Merle's motions for directed verdict, because the HMO statutes and the Alabama "twisting" statute were laws regulating insurance and, under the evidence, could be the basis of Mentam's cause of action. Prior to final judgment, Mentam's complaint did not mention or purport to be brought under either statute.

The HMO statutes did not become effective until May 29, 1986, almost a year after Mentam's cause of action accrued. As a general rule, statutes, except remedial statutes, will not be construed to have retroactive effect unless the language of the statute expressly indicates that the Legislature so intended. *Jones v. Causey*, 445 So.2d 873 (Ala. 1983). There is no expression of legislative intent that the HMO statutes apply to causes of action that accrued prior to the effective date of that legislation. This Court defined remedial statutes in *Stowe v. City of Anniston*, 381 So.2d 26, 29 (Ala. 1980), as "those relating to remedies or modes of procedure, which do not create new rights or take away vested ones." For Mentam's cause of action to be saved from preemption by the HMO statutes, the statutes would have to regulate insurance and give him a new private cause of action. A statute creating a new right, a new cause of action, is clearly substantive in nature and would not be given retroactive application in the absence of a provision indicating a contrary legislative intent. I need not address whether the HMO statutes create a private cause of action, for if they do they will not be given retroactive effect. Therefore, I need not discuss whether the Alabama HMO statutes "regulate insurance," for Mentam's cause of action for misrepresentation is not saved from preemption by the HMO statutes.

The purpose for Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") is expressed in § 27-12-1 as:

> "The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined."

Section 27-12-6 ("Twisting)" provides:

> "*No person* shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy." (Emphasis supplied).

Section 27-1-2(3) defines "person" for the purposes of Title 27 as follows:

> "An individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity."

Section 27-1-2(2) defines "insurer" for the purposes of Title 27 as follows:

> "Every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance."

In *Pilot Life*, supra, Dedeaux did not contend that his cause of action for fraud in the inducement was a law that regulated insurance and was thus saved from preemption, so this was not discussed by Justice O'Connor in her opinion. Dedeaux did contend that the cause of action for bad faith did regulate insurance and was saved from preemption by § 514(b)(2)(A). In regard

to this, Justice O'Connor wrote that the Court first took "what guidance was available from a 'common-sense view' of the language of the saving clause itself." 481 U.S. at 48, 107 S.Ct. 1553 (*"any law of any State which regulates insurance"*). "Second," she wrote, "we made use of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in interpreting the saving clause"; and, she noted that in doing so the Court used these criteria:

> " '[*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' "

481 U.S. at 49, 107 S.Ct. at 1553.

In applying the "common sense view," Justice O'Connor reasoned that the phrase "regulates insurance" does not support the argument that the Mississippi law of bad faith falls under the saving clause, since the Mississippi Supreme Court, as early as 1915, had recognized that punitive damages were available in a contract case when " 'the act or omission constituting the breach of any [contract, not just an insurance] contract amounts also to the commission of a tort.' "

> "Certainly a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause. A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots

> of this law are firmly planted in the general principles of Mississippi tort and contract law."

481 U.S. at 50, 107 S.Ct. at 1554.

The Alabama "twisting" statute appears to be directed toward the insurance industry. However, since 1907, the Alabama Legislature has provided a civil action for "[m]isrepresentations of a material fact made willfully to deceive, or recklessly without knowledge." § 6-5-101. The Alabama Supreme Court, at least since 1933, has allowed punitive damages to be recovered in such misrepresentation actions, when the misrepresentations were made by the defendant with the intent to defraud the plaintiff. *Cartwright v. Hughes*, 226 Ala. 464, 147 So. 399 (1933). So the roots of misrepresentation were firmly planted in the general principles of Alabama tort law, before the Legislature enacted the "twisting" statute in 1971. Until the post-final judgment amendment of his complaint, Menton had pursued his civil action against HealthAmerica and Merle under this firmly planted general principle of Alabama tort law.

In *Pilot Life*, supra, the United States Supreme Court found that the factors set out in the McCarran-Ferguson Act did not support Dedeaux's assertion that the Mississippi law of bad faith "regulates insurance," for (1) it did not affect a spreading of policyholder risk; (2) "[t]he state common law of bad faith is . . . no more 'integral' to the insurer-insured relationship than any State's general contract law is integral to a contract made in that State." 481 U.S. at 51, 107 S.Ct. at 1555; and (3) "Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract case." 481 U.S. at 51, 107 S.Ct. at 1555. The Court then held "the Mississippi common law of bad faith at most meets one of the three criteria used to identify the 'business of insurance' under

the McCarran-Ferguson Act, and used in *Metropolitan Life* to identify laws that 'regulat[e] insurance' under the saving clause."

I do not find that the "twisting" statute affected a spreading of the risks among policyholders; or that the "twisting" statute is more integral to the insurer-insured relationship than Alabama's misrepresentation statute, as developed from general principles of tort law; or that the statute in its definition of "person" and "insurer" is limited to entities in the insurance business.[2] Therefore, using Justice O'Connor's criteria for determining when a state law "regulates insurance" and is therefore saved from ERISA preemption, I would find that the "twisting" statute does not save Menton's claim from preemption. By this, I do not mean to imply that Alabama's "twisting" statute affords a private cause of action to Menton.[3] I need not reach this issue.

A unanimous United States Supreme Court in *Pilot Life*, supra, held that Dedeaux's state law claims, includ-

---

[2] Alabama Code 1975, § 27-12-24, provides:

> "No *insurer* shall, without just cause, refuse to pay or settle claims arising under coverages provided by its policies in this state. . . ." (Emphasis supplied.)

From the pleadings in *Belasco v. W.K.P. Wilson & Son, Inc.*, supra, we cannot determine whether this Code section, which is contained in Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") was relied on by *Belasco* as a law regulating insurance.

> "Plaintiffs argue that the Alabama law of bad faith, which forms the basis of one of their claims, is a 'law . . . which regulates insurance,' 29 U.S.C. § 1144(b)(2)(A), and therefore falls under the saving clause. However, the Alabama law of bad faith appears to us to have the same roots 'in the general principles of . . . tort and contract law' as was the case in *Dedeaux*."

833 F.2d at 281.

[3] In *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989), the Eleventh Circuit Court of Appeals held that the Alabama twisting statute does not create a private cause of action.

ing bad faith and fraud in the inducement, were preempted, even though Dedeaux elected not to assert any of the remedies that would be available under ERISA. Menton elected not to assert any of the remedies that would be available to him under ERISA, i.e., to clarify and enforce his rights under the terms of the plan as represented to him, and to obtain equitable relief (reformation of the health insurance contract to remove the time limitation on physical therapy and orthopedic appliances benefits), etc. 29 U.S.C. § 1132(a). These benefits and an award of attorney fees could have been available to Menton under ERISA, whether he sued in federal or in state court, if he had prevailed on his ERISA claim. *Pilot Life*, 481 U.S. at 53, 107 S.Ct. at 1556. Therefore, ERISA did not deny Menton a remedy. At the conclusion of *Pilot Life*, 481 U.S. at 57, 107 S.Ct. at 1558, Justice O'Connor wrote:

> "*Metropolitan Life* [*Ins. Co. v. Massachusetts*, supra], did not involve a state law that conflicted with a substantive provision of ERISA. Therefore the Court's general observation—that state laws related to ERISA may also fall under the saving clause —was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law. In particular, the Court had no occasion to consider in *Metropolitan Life* the question raised in the present case: whether Congress might clearly express, through the structure and legislative history of a particular substantive provision of ERISA, an intention that the federal remedy provided by that provision displace state causes of action. . . .
>
> "Considering the common-sense understanding of the saving clause, the McCarran-Ferguson Act factors defining the business of insurance, and, most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive,

> we conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and therefore is pre-empted by § 514(a)."

This action was filed while *Hood v. Prudential Ins. Co. of America*, supra (*Hood I*), was the law. Prior to final judgment in this case, the United States Supreme Court decided *Pilot Life*, supra, and we decided *Seafarers' Welfare Plan v. Dixon*, supra. However, it was after final judgment in this case that this Court reversed *Hood v. Prudential Ins. Co. of America*, supra (*Hood II*) and decided *Landy v. Travelers Insurance Co., supra.* Therefore, I would reverse the judgment of the trial court; however, rather than rendering judgment or remanding with instructions that the trial court grant Health-America and Merle's motion for JNOV, I would reverse and remand and afford Menton the opportunity to amend to state a claim under ERISA.

At the time this complaint was filed, Menton had every reason to believe, every reason to predict, that his state law cause of action asserting misrepresentation of coverage afforded by a health insurance plan would not be preempted by ERISA. See *Hood I.* During the course of this litigation in the circuit court and during this appeal, the rules were changed. This Court could not and did not predict this. See *Hood I.*

I, as a member of the Supreme Court of Alabama, will not thwart an opportunity for a remedy for one whose right to a particular remedy was foreclosed only by his astute attorneys' not being able to guess how Justices would rule. It seems appropriate and altogether just to invoke equitable relief, which is afforded by 29 U.S.C. § 1132(a)(3), to one whose civil cause of action was foreclosed by an expansion of the ERISA preemption after that cause of action had accrued and after an action to enforce it had been filed. See, *Culberson v. Bankers Life Co.*, 541 So.2d 480 (Ala. 1989).

I would reverse and remand to permit Menton to amend and proceed with a cause of action under ERISA, 29 U.S.C. § 1132(a). Therefore, I dissent.

Maddox, J., concurs.

APPENDIX B

Mailing Address: Telephone: 261-4609
P.O. Box 157
Montgomery, Alabama 36101

OFFICE OF
CLERK OF THE SUPREME COURT
STATE OF ALABAMA
MONTGOMERY

Re: 87-1100

HEALTH AMERICA AND PAMELA MERLE
Appellant

vs.

EDWARD MENTON
Appellee

You are hereby notified that the following indicated action was taken in the above cause by the Supreme Court today:

——— Appeal docketed. Future correspondence should refer to the above number.

——— Court Reporter granted additional time to file reporter's transcript to and including

——— Clerk/Register granted additional time to file clerk's record/record on appeal to and including

——— Appell———granted 7 additional days to file briefs to and including

——— Appellant(s) granted 7 additional days to file reply briefs to and including

——— Record of Appeal filed

——— Appendix Filed

——— Submitted on Briefs

——— Petition for Writ of Certiorari denied. No opinion.

xxxx

——— Application for rehearing overruled. No opinion written on rehearing.

——— Permission to file amicus briefs granted

———

9/15/89
bsa

/s/ Robert G. Esdale
ROBERT G. ESDALE
Clerk
Supreme Court of Alabama

APPENDIX C

IN THE CIRCUIT COURT
OF MOBILE COUNTY, ALABAMA

Civil Action No. CV-86-003049

EDWARD MENTON,
Plaintiff,

vs.

HEALTH AMERICA and PAMELA MERLE,
Defendants.

ORDER

[Filed June 13, 1988]

On the 18th day of May, 1988, came to be heard Defendants' Motion for Judgement Notwithstanding the Verdict or, In the Alternative, for New Trial or, In the Alternative, for Remittitur. Having considered the motions; the pleadings and other papers on file herein, the evidence adduced at trial and objections and proceedings in the course of the trial; the case law and other authority cited by all parties either pretrial, during trial, or post trial; and the argument of counsel, it is ORDERED, ADJUDGED, and DECREED as follows:

1.(a) That Defendants' motion for judgement notwithstanding the verdict is due to be and hereby is DENIED;

(b) The Defendants' motion for new trial is due to be and hereby is DENIED;

(c) That Defendants' motion for remittitur is due to be and hereby is DENIED.

2. In connection with all of Defendants' motions, the Court has considered Defendants' claims tha the imposition of punitive damages, both generally under Alabama law and specifically in the amount and as returned by the jury under the facts of this case, is unconstitutional under the Alabama as well as the United States Constitutions (particularly, the Due Process Clause of the 5th Amendment; the Due Process, Equal Protection, and Privileges and Immunities Clauses of the 14th Amendment; the Excessive Fines Clause of the 8th Amendment; the Contracts Clause and prohibition of Ex Post Facto laws of Article I, Section 10, Clause 1). Although these arguments were timely raised and effectively presented, the Court is unpersuaded by such arguments and therefore holds that the imposition of punitive damages, both generally under Alabama law and specifically in the amount as returned by the jury under the facts of this case, is constitutional under both the state and federal constitutions.

3. With respect to Defendants' Motion for a Remittitur, Alabama Law is that a remittitur or new trial should not be ordered on the grounds of excessiveness of the jury's verdict except where the court can clearly see that the verdict is tainted by bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury.

The Court has carefully considered all of the evidence in the case on all issues. The Court has carefully considered the nature and quality of the testimony of all of the witnesses, as well as the demeanor of each witness while testifying. The Court has further reviewed its Charge to the jury on the issue of damages and has found that it correctly instructed the jury on damages. As a part of the charge, the jury was instructed that if they found in favor of the Plaintiff, Edward Menton, and against the Defendants, Health America and Pamela Merle, that in assessing damages they should take into consideration

and give due regard to the enormity of the wrong and the necessity of preventing similar wrongs in the future.

After a careful review by the Court of the entire trial of the case, including the testimony of all of the witnesses, all of the documentary and demonstrative evidence produced at trial, the Court's observation of all parties and witnesses, and the Court's Carge to the jury on damages, the Court is convinced that the jury carefully and conscientiously follows the Court's instructions is assessing damages in the case at $1,800,000.00, and that the award is consistent with the Court's instructions and supported by the evidence.

The Court finds, after a review of the entire trial, that the central issue presented in the Defendants' Motion for Remittitur is whether or not the jury verdict of $1,800,000.00 in this case is in and of itself evidence of bias, passion, prejudice, corruption or other improper motive or cause. The Court cannot call to mind or have the attorneys for the Defendants shown to the Court any factor at all that could be construed to indicate bias, passion, prejudice, corruption or other improper motive or cause on the part of the jury. On the contrary, the Court finds that there was clear and convincing evidence of fraud on the part of the Defendants, Health America and Pamela Merle, which in the Court's opinion fully justified the jury's verdict.

The Court finds that the $1,800,000.00 verdict is not excessive and is not the result of bias, passion, prejudice, corruption, or other improper motive or cause.

DONE and ORDERED this 13th day of June, 1988.

/s/ Braxton L. Kittrell
BRAXTON L. KITTRELL
Judge
Circuit Court of Mobile County

APPENDIX D

FEDERAL STATUTORY AND CONSTITUTIONAL PROVISIONS

SUBTITLE A—GENERAL PROVISIONS

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current min-

SUBTITLE B—REGULATORY PROVISIONS

Part I—Reporting and Disclosure

Cross References

Criminal penalties under this part, see section 1132 of this title.

§ 1021. Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneciaries

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 1022(a)(1) of this title; and

(2) the information described in section 1024(b)(3) and 1025(a) and (c) of this title.

* * * *

§ 1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in setcion 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such particpnats and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood

by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b) of this section) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in the information described in subsection (b) of this section shall be filed in accordance with section 1024 (a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirement respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

(Pub. L. 93-406, Title I, § 102, Sept. 2, 1974, 88 Stat. 841.)

§ 1024. Filing and furnishing of information

* * * *

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan

Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary, plan description, and all modifications and changes referred to in section 1022 (a) (1) of this title—

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, every fifth year after the plan becomes subject to this part an updated summary plan description described in section 1022 of this title which integrates all plan amendments made within such five-year period, except that in a case where no amendments have been made to a plan during such five-year period this sentence shall not apply. Notwithstanding the foregoing, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, the summary plan description described in section 1022 of this title every tenth year after the plan becomes subject to this part. If there is a modification or change described in section 1022(a) (1) of this title, a summary description of such modification or charge shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan.

(2) The administrator shall make copies of the plan description and the latest annual report and the bargaining agreement, trust agreement, contract, or other instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the administration and in such other places as may be necessary to make available all pertinent information to all participants (including such places as the Secretary may prescribe by regulations).

(3) Within 210 days after the close of the fiscal year of the plan, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, a copy of the statements and schedules, for such fiscal year, described in subparagraph (A) and (B) of section 1023(b)(3) of this title and such other material (including the percentage determined under section 1023(d)(11) of this title) as is necessary to fairly summarize the latest annual report.

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

* * * *

Part 4—Fiduciary Responsibility

§ 1101. Coverage

(a) This part shall apply to any employee benefit plan described in section 1003(a) of this title (and not exempted under section 1003(b) of this title), other than—

(1) a plan which is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees; or

(2) any agreement described in section 736 of Title 26, which provides payments to a retired partner or deceased partner or a deceased partner's successor in interest.

* * * *

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses unless

under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions this subchapter or subchapter III of this chapter.

* * * *

§ 1109. Liability for breach of fiduciary duty

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

(b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this subchapter if such breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

(Pub.L. 93-406, Title I, § 409, Sept. 2, 1974, 88 Stat. 886.)

Part 5—Administration and Enforcement

§ 1131. Criminal penalties

Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than $5,000 or imprisoned not more than one year, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding $100,000.

(Pub.L. 93-406, Title I, § 501, Sept. 2, 1974, 88 Stat. 891.)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as therwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

* * * *

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty of up to $1,000 a day from the date of a plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

* * * *

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * * *

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * *

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

* * * *

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title).

* * * *

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State

for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the busines of insurance to the extent that such business is not regulated by State law.

Mar. 9, 1945, c. 20, § 2, 59 Stat. 34; July 25, 1947, c. 326, 61 Stat. 448.

AMENDMENT XIV—CITIZENSHIP; PRIVILEGES AND IMMUNITES; DUE PROCESS; EQUAL PROTECTON; APPORTIONMENT OF REPRESENTATION; DISQUALIFICATION OF OFFICERS; PUBLIC DEBT; ENFORCEMENT

Materials for the Citizenship and Privileges and Immunities Clauses of Section 1 are set out in this volume. See the following three volumes for materials pertaining to the Due Process and Equal Protection Clauses of that section and Section 2 to 5.

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

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ARTICLE VI—DEBTS VALIDATED—SUPREME LAW OF LAND—OATH OF OFFICE

Cl. 2. Supreme Law of Land.

* * * *

This Constitution, and the Laws of the United States which shall be made in Pursuant thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

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APPENDIX E

STATE STATUTES

§ 27-12-6. "Twisting."

No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy. (Acts 1971, No. 407, p. 707, § 232.)